

5531

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>119 N. Cannon Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>THERESA</u> Last <u>BAKER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 16, 1887</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Company</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Calvin Baker</u>				14. MOTHER'S MAIDEN NAME <u>Beda Harbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-5082</u>		17. INFORMANT <u>Miss. Rosie G. Baker</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute dilatation of heart</u> <u>601X</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Hydrourephrosis</u> (c) <u>obesity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. <u>  </u> p. <u>  </u> m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
				20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>May 8, 1956</u> to <u>May 19, 1956</u> , that I last saw the deceased alive on <u>May 19, 1956</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>				ADDRESS (Street, city or town, state) <u>159 W. Washington St., Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>				DATE SIGNED <u>May 21, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/22/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Franklin</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>May 21, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1911		Maryland		Baltimore		Maryland		United States	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		RE-MARRIED		OTHER			
DATE OF MARRIAGE		1935		1935		1935		1935		1935		1935		1935	
DATE OF DEATH		1956		1956		1956		1956		1956		1956		1956	
PLACE OF DEATH		Home		Home		Home		Home		Home		Home		Home	
CITY		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore	
STATE		Maryland		Maryland		Maryland		Maryland		Maryland		Maryland		Maryland	
COUNTRY		United States		United States		United States		United States		United States		United States		United States	
CAUSE OF DEATH		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease	
MANNER OF DEATH		Natural		Natural		Natural		Natural		Natural		Natural		Natural	
DATE OF REPORT		1956		1956		1956		1956		1956		1956		1956	
REPORTED BY		Physician		Physician		Physician		Physician		Physician		Physician		Physician	
SIGNATURE		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE		1956		1956		1956		1956		1956		1956		1956	

BUREAU V. S.

MAY 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05527

5532

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN '1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>			d. STREET ADDRESS <u>SHARPSBURG</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Benner</u>			4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 10, 1876</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ROHRSERSVILLE, MD</u>	
13. FATHER'S NAME <u>JOHN LAPOLE</u>			14. MOTHER'S MAIDEN NAME <u>MARY REEDER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>MR. Robert Benner SHARPSBURG, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>463X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Phlebotrombosis - Pelvis &amp; Vens left leg</u> DUE TO (c) <u>Absolute bed rest with Arthritis severe</u>					INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>10 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent pyloric obstruction due to Cortisone Rx</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5 May</u> , 19 <u>56</u> , to <u>31 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>31 May</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Frank E. Drumbach</u>		M.D.		ADDRESS (Street, city or town, state) <u>170 West Washington St</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Drumbach</u>		Hagerstown Maryland		DATE SIGNED <u>June 1, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW Cem.</u>	
22d. LOCATION (City, town, or county) <u>Sharpsburg, MD.</u>		22e. (State) <u>MD.</u>		22f. REC'D BY REGISTRAR <u>June 1, 1956</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter L. Wolf Williamsport, Md.</u>		ADDRESS <u>Williamsport, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

1882

245158

35 9 97 258101.2

124

MAX FEDEX

Robert Brown - Shattuck

107

[illegible]

06/08/2017 17:32 VLT View (cont.)

Temperature 55° F.

BUREAU V.

1956 7 14

RECEIVED



## 5533 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>Penn.</u>	COUNTY <u>Franklin</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>8 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	STATE <u>State Line</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington B. Hospital</u>		STREET ADDRESS <u>State Line</u>	<u>75X-3</u>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Edith</u>	(Middle)	(Last) <u>Bowders</u>	(Month) <u>5</u> (Day) <u>3</u> (Year) <u>1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1/30/1879</u>
9. AGE last birthday: <u>77</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Leitersburg Maryland</u>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>House wife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry Minor</u>		14. MOTHER'S MAIDEN NAME: <u>Unable to Obtain</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mr. Lloyd Bowders, RD #2, Hagerstown, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
(a) <u>B. LATIPAN PULMONARY TUBERCULOSIS</u>		<u>YEARS -</u>	
(b) <u>Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>ARTERIO-SCLEROTIC HEART DISEASE</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUN 1955</u> , to <u>MAY 1956</u> , that I last saw the deceased alive on <u>2 MAY 1956</u> and that death occurred at <u>12:29 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Webster MD</u>		DATE SIGNED <u>5/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Beautiful View Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 4 1956</u>		FUNERAL DIRECTOR <u>Shirley M. Greenman, Greenville, Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

MAY 7 1956

RECEIVED

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Dr. Jennings  
5534 05529  
CERTIFICATE OF DEATH  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 wk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Cty. Hospital</u>				d. STREET ADDRESS <u>107 E. Antietam St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Thomas Bower</u>				4. DATE OF DEATH Month Day Year <u>May 5 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1877</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bestera Green House</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Daniel Bower</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Stem</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>313-24-8708</u>		17. INFORMANT Address <u>Mrs. Annie Bower (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>603X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis of Pelvic veins?</u> DUE TO (c) <u>Postoperative</u>				107 E. Antietam St.		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Ureterotomy performed April 28, 1956</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 27</u> , 19 <u>56</u> , to <u>May 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>56</u> , and that death occurred at <u>11:57 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Jennings</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>136 W. Washington St Hagerstown, Md. 5/7/56</u>			
PHYSICIAN'S NAME (Type) <u>George Jennings</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Centerv</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>May 8, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Shast Bowers</u>	

BUREAU V. S.

MAY 10 1956

RECEIVED

5535

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>			d. STREET ADDRESS <b>32 Wayside Ave.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Baby Krista Ann Bowers</b>			4. DATE OF DEATH <b>May 30 19 56</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29 1956</b>		9. AGE (In years last birthday) yrs. <b>17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Eugene Bowers</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Houser</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Mr. Eugene Bowers</b>			32 Wayside Ave. Hagerstown Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage of Subarachnoid Space.</b> DUE TO <b>760.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Oedema of the Brain.</b> DUE TO <b>Tear of the Tentorium Cerebellar.</b> (c) <b>?</b>					INTERVAL BETWEEN ONSET AND DEATH <b>17 hours.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>May 29, 1956</b> , to <b>May 30, 1956</b> , that I last saw the deceased alive on <b>May 30, 1956</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>2146 Somerset St. Hagerstown Md.</b>	
PHYSICIAN'S NAME (Type) <b>[Signature]</b>				DATE SIGNED <b>May 31, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Williamsport Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>				24a. REC'D BY REGISTRAR <b>May 31, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





5536

## CERTIFICATE OF DEATH

Reg. No. 15531

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Highfield</u>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Edward</u> Last <u>Bowman</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 8, 1869</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pleasant Valley</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Bowman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Warner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs Oscar McClaf, Highfield Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, Nephrosclerosis</u> <u>550.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Appendiceal abscess with rupture and generalized peritonitis, Appendectomy 5-2-56</u> (c) <u>Acute Appendicitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>4 weeks</u> <u>5 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Transient auricular fibrillation</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Highfield</u>				20g. (County) <u>Washington</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>5-2-56</u> , 19 <u>56</u> , to <u>May 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>56</u> , and that death occurred at <u>7:50 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Omar D. Sprecher, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>314 N/ Potomac Street, Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Omar D. Sprecher, Jr., M.D.</u>				DATE SIGNED <u>June 1, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley</u>		22d. LOCATION (City, town, or county) (State) <u>Pleasant Valley Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Groves, Waynesboro Pa.</u>				24a. REC'D BY REGISTRAR <u>June 1, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Z. Groves</u>	

MEDICAL CERTIFICATION

TO PRIVATE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5535

DATE OF DEATH		PLACE OF DEATH		MARRIAGE		A FULL BLOOD RELATIVE OF DECEASED	
JUN 4 1956		BALTIMORE, MARYLAND		JAN 15 1955		JAMES H. HARRIS	
AGE		SEX		RACE		EDUCATION	
45		M		W		HIGH SCHOOL	
DATE OF BIRTH		PLACE OF BIRTH		MOTHER'S NAME		FATHER'S NAME	
JUN 15 1911		BALTIMORE, MARYLAND		JANE HARRIS		JAMES HARRIS	
DATE OF DEATH		PLACE OF DEATH		MARRIAGE		A FULL BLOOD RELATIVE OF DECEASED	
JUN 4 1956		BALTIMORE, MARYLAND		JAN 15 1955		JAMES H. HARRIS	
AGE		SEX		RACE		EDUCATION	
45		M		W		HIGH SCHOOL	
DATE OF BIRTH		PLACE OF BIRTH		MOTHER'S NAME		FATHER'S NAME	
JUN 15 1911		BALTIMORE, MARYLAND		JANE HARRIS		JAMES HARRIS	
DATE OF DEATH		PLACE OF DEATH		MARRIAGE		A FULL BLOOD RELATIVE OF DECEASED	
JUN 4 1956		BALTIMORE, MARYLAND		JAN 15 1955		JAMES H. HARRIS	
AGE		SEX		RACE		EDUCATION	
45		M		W		HIGH SCHOOL	
DATE OF BIRTH		PLACE OF BIRTH		MOTHER'S NAME		FATHER'S NAME	
JUN 15 1911		BALTIMORE, MARYLAND		JANE HARRIS		JAMES HARRIS	

BUREAU V. 2

JUN 4 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>918 LANVALE ST.</b>	
3. NAME OF DECEASED (Type or print) <b>BRIAN ANDREW BRADLEY</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/13/1955</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	9. AGE (In years lost birthday) yrs. <b>11</b> Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.
13. FATHER'S NAME <b>PAUL BERNARD BRADLEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>NO</b>		14. MOTHER'S MAIDEN NAME <b>JANICE BEALL</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. JANICE BRADLEY</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>754.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Heart Disease (Transposition of Great Vessels)</b> DUE TO (c) <b>11 mo</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August</b> , 1955, to <b>May 10</b> , 1956, that I last saw the deceased alive on <b>May 10</b> , 1956, and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A.M. Bacon Jr</b>		DATE SIGNED <b>302 N. Potomac / Hagerstown Md 5/11/56</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/12/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Normant, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 14 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Libert H. Bacon</b>

TO BE FILLED BY THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached and filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05533

Dr. Jennings

5538

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>81 Washington County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. STREET ADDRESS <u>334 N. Mulberry St.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE GERTRUDE BREZLER</u>		4. DATE OF DEATH Month Day Year <u>May 6 19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian G. Brezler</u>		14. MOTHER'S MAIDEN NAME <u>Clara Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>014-09-4713</u>	
17. INFORMANT <u>Mr. Clarence Brezler</u>		Address <u>534 N. Mulberry</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Heart muscle</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Thrombosis</u> (c) <u>Arteriosclerosis generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>48 hrs.</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 4</u> , 19 <u>56</u> , to <u>May 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>56</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George Jennings</u> M.D. <u>136 W. Washington St.</u> <u>May 7, 1956</u> PHYSICIAN'S NAME (Type) <u>George Jennings, M.D.</u> <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-9-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>May 8, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Clarence Brezler</u>	

BUREAU V. S.

MAY 10 1956

RECEIVED

TO BE FILLED BY REGISTRAR OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Lusby

5539

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

05534

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8/ Washington County Hospital</u>				d. STREET ADDRESS <u>436 North Prospect St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE VICTORIA BRUNNER</u>				4. DATE OF DEATH Month Day Year <u>May 8, 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 21, 1886</u>	
9. AGE (In years last birthday) yrs. <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Smithsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Smith</u>				14. MOTHER'S MAIDEN NAME <u>Clara Wolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Tyson E. Brunner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis rt. femoral artery</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260x</u> (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Severe Generalized Arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 yrs +</u> <u>10 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>8 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7 May</u> , 19 <u>56</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				M.D. <u>2301 Potomac</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>	
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>						DATE SIGNED <u>8 May 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>May 11, 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	

CERTIFICATE OF DEATH

330

Page One of

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE REGISTRAR	
NAME OF DECEASED		NAME OF DECEASED	
AGE		AGE	
SEX		SEX	
RACE		RACE	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		DATE OF REGISTRATION	
PLACE OF REGISTRATION		PLACE OF REGISTRATION	
NAME OF REGISTRAR		NAME OF REGISTRAR	
OFFICE OF REGISTRAR		OFFICE OF REGISTRAR	
COUNTY OF REGISTRAR		COUNTY OF REGISTRAR	
STATE OF REGISTRAR		STATE OF REGISTRAR	
FEDERAL BUREAU OF INVESTIGATION		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		WASHINGTON, D.C.	
RECEIVED		RECEIVED	
MAY 14 1956		MAY 14 1956	
BUREAU V. S.		BUREAU V. S.	

5590

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BIG SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BIG SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CHARLES MILL ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>LOUIS</b> Last <b>CHARLES</b>			4. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>19 56</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT, 17, 1887</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILLER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GRAIN MILLING</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN F. CHARLES</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. GARDNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-20-2492</b>		17. INFORMANT Address <b>MRS. MARY CHARLES BIG SPRING, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Bowell.</b> <b>153+</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation 1 year ago but metastasis set in.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1956</b> to <b>May 25, 1956</b> , that I last saw the deceased alive on <b>May 24, 1956</b> , and that death occurred at <b>12 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.		ADDRESS (Street, city or town, state) <b>Clear Spring Md. 56652</b> DATE SIGNED <b>May 27/56</b>					
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/29/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b>		ADDRESS <b>Clear Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>May 27/56</b>		24b. REGISTRAR'S SIGNATURE <b>Joseph W. Murray</b>	

MEDICAL CERTIFICATION

TO BE FILLED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE IN ENVELOPE		COUNTY	
MAY 1956		MAY 1956	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
MARRIAGE		MARRIAGE	
RELIGION		RELIGION	
BIRTH		BIRTH	
DEATH		DEATH	
SIGNATURE		SIGNATURE	
DATE		DATE	
PLACE		PLACE	
COUNTY		COUNTY	
STATE		STATE	
FEDERAL BUREAU OF INVESTIGATION		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		WASHINGTON, D.C.	

BUREAU V. S.

JUN 1 1956

RECEIVED

5540

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>60 years</b> <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>734 Guilford Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Madge</b> First <b>May</b> Middle <b>Clark</b> Last		4. DATE OF DEATH <b>May</b> Month <b>1</b> Day <b>19</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1873</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John H. Clark</b>		14. MOTHER'S MAIDEN NAME <b>Margaret R. Matchett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Emily Poffenberger Hagerstown Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stypticus - arteriosclerotic heart disease</b> DUE TO (c) <b>16 yrs - ?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-14-1940</b> to <b>5-1-1956</b> , that I lost saw the deceased olive on <b>5-1-1956</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 W. Washington St. - Hagerstown - Md.</b> DATE SIGNED <b>5/1/56</b>			
ACTUAL SIGNATURE <b>John A. Hager</b> M.D.		PHYSICIAN'S NAME (Type) <b>Hagerstown - Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-4-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>May 8, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Blair H. Powers</b>	

MEDICAL CERTIFICATION

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	
John H. Clark		45		Male		Married		Farmer		Heart Disease		1956		Bathmore		J. H. Clark		J. H. Clark	
Name of Deceased		Age		Sex		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	
Mary Elizabeth Harrison		35		Female		Married		Housewife		Heart Disease		1956		Bathmore		J. H. Clark		J. H. Clark	
Name of Deceased		Age		Sex		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	
John H. Clark		45		Male		Married		Farmer		Heart Disease		1956		Bathmore		J. H. Clark		J. H. Clark	
Name of Deceased		Age		Sex		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	
Mary Elizabeth Harrison		35		Female		Married		Housewife		Heart Disease		1956		Bathmore		J. H. Clark		J. H. Clark	

BUREAU V. S.

MAY 10 1956

RECEIVED

5591

## CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>N. MARTIN ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> <b>FINLEY</b> <b>CLOPPER</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 6, 1891</b>	
9. AGE (In years last birthday) yrs. <b>64</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HIGH SCHOOL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JOSEPH F. CLOPPER</b>			
14. MOTHER'S MAIDEN NAME <b>SALLY SUFFECOL</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>214-09-7118</b>				17. INFORMANT <b>LYDIA V. CLOPPER</b> Address <b>CLEAR SPRING</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> <b>193X</b> DUE TO Glioblastoma of the Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>7 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct 15, 1955</b> to <b>May 21, 1956</b> , that I last saw the deceased alive on <b>May 21, 1956</b> , and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.				ADDRESS (Street, city or town, state) <b>Clear Spring, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>				DATE SIGNED <b>5/22/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 24, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BLAIRS VALLEY</b>		22d. LOCATION (City, town, or county) (State) <b>BLAIRS VALLEY WASH. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b> Address <b>Clear Spring, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>May 23, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Joseph W. Murray</b>	

MEDICAL CERTIFICATION

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the physician's signature and the signature of the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF BURIAL PLACE		16. SIGNATURE OF OTHER		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
---------------------	--	--------	--	--------	--	---------	--	------------------	--	-------------------	--	------------------	--	-------------------	--	-------------------	--	---------------------	--	----------------------------	--	---------------------------	--	----------------------------	--	-------------------------------	--	-------------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	------------------------	--	-------------------------	--

BUREAU V. B.

MAY 25 1956

RECEIVED



5541

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>18 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>DAVIS, JR.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1956</b>
9. AGE (In years last birthday) yrs. <b>18</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Edward Davis, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Esta Lee Rowe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Charles E. Davis, Sr. Fairplay, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abletactasis, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity (2 lbs 4 oz)</b> DUE TO (c) <b>thus.</b> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. <b>19</b> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/22</b> , 19 <b>56</b> , to <b>5/22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/22</b> , 19 <b>56</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>N. Potomac St. Hagerstown Md.</b> DATE SIGNED <b>5/23</b>			
ACTUAL SIGNATURE <b>Richard A. Young</b>		PHYSICIAN'S NAME (Type) <b>Richard A. Young</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/23/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Manor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tilghmanton Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Berger</b>		24a. REC'D BY REGISTRAR <b>May 24, 1956</b>	
ADDRESS <b>Hagerstown, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Phas H. Bowers</b>	

MAY 28 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05539

Reg. Dist. No. 303

Dr. Wells

5542

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20 Summit Ave.</u>				d. STREET ADDRESS <u>20 Summit Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUY LUTHER DOUB</u>				4. DATE OF DEATH Month Day Year <u>May 19, 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1888</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Broker</u>		11. BIRTHPLACE (State or foreign country) <u>nr. Funkstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David C. Doub</u>				14. MOTHER'S MAIDEN NAME <u>Sarah C. Eakle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW#1</u>		16. SOCIAL SECURITY NO. <u>WW#1</u>		17. INFORMANT Address <u>Mr. Harry F. Doub-132 E. Antietam St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arterio-sclerosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic myocardial heart disease</u> (c), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none 19</u>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>none</u>		(County) <u>none</u>	(State) <u>none</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		5-21-56	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-22-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>May 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

MAY 28 1956

RECEIVED

TO BE SIGNED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5543

## CERTIFICATE OF DEATH

05540  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>			d. STREET ADDRESS <u>603 West Franklin Street</u>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Catherine</u> Last <u>Finks</u>			4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>19 56</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 11, 1884</u>		9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Berkeley Co. W. Va.</u>
13. FATHER'S NAME <u>Thomas Drennen</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Welsh</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Miss Lida Drennen, Hagerstown, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia (6 days) due to Arterio-nephrosclerosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> 2 years					INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 22, 1956</u> , to <u>May 27, 1956</u> , that I last saw the deceased alive on <u>May 27, 1956</u> , and that death occurred at <u>8:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg. 5-28-56</u> DATE SIGNED					
ACTUAL SIGNATURE <u>Wm. T. Layman</u>			M.D. <u>100 Professional Arts Bldg. 5-28-56</u>		
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>			<u>Hagerstown, Maryland</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-30-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. T. Layman</u>			ADDRESS <u>305 N. Patuxent St. Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>May 28, 1956</u>
					24b. REGISTRAR'S SIGNATURE <u>Wm. T. Layman</u>



RECEIVED

5544

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1163 Hamilton Blvd.</u>				d. STREET ADDRESS <u>14 Carroll St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rhoda Brandt Fogelsanger</u>				4. DATE OF DEATH Month Day Year <u>May 28 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1886 - 1890</u>	9. AGE (In years last birthday) <u>60-70</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Milton Huber Brandt</u>				14. MOTHER'S MAIDEN NAME <u>Mary Zook Wenger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Robt. Martin</u> Address <u>1163 Hamilton Blvd. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral atherosclerosis</u> DUE TO (c) <u>Generalized atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1956</u> , to <u>May 28, 1956</u> , that I last saw the deceased alive on <u>May 28, 1956</u> , and that death occurred at <u>12:00M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. L. Packer, Jr.</u>				ADDRESS (Street, city or town, state) <u>145 W. Washington St.</u>		DATE SIGNED <u>5/29/56</u>	
PHYSICIAN'S NAME (Type) <u>L. L. Packer, Jr. M.D.</u>				<u>145 W. Washington St.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Hart</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>May 31, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phas. H. Flowers</u>			

MEDICAL CERTIFICATION

TO BE FILLED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filled by the hospital or attending physician.

TO BE FILLED BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1910		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
Carpenter		High School		Married		Catholic		White		White		5' 10"		175	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
Heart Disease		Natural		3 weeks		JAN 25 1956		BALTIMORE		MD		MD		USA	
SIGNS AND SYMPTOMS		HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES		HISTORY OF SURGICAL OPERATIONS		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO		HISTORY OF OTHER HABITS	
Chest pain, shortness of breath, swelling of feet		Onset 2 weeks ago, gradual		Hypertension, Diabetes		None		None		None		None		None	
TREATMENT		HOSPITAL		PHYSICIAN		NURSE		LABORATORY		X-RAY		AUTOPSY		OTHER	
St. Mary's Hospital		Dr. J. H. Smith		Mrs. J. H. Smith		None		None		None		None		None	
DATE OF AUTOPSY		PLACE OF AUTOPSY		NAME OF PATHOLOGIST		NAME OF ASSISTANT		NAME OF NURSE		NAME OF LABORATORY		NAME OF X-RAY		NAME OF OTHER	
JAN 28 1956		St. Mary's Hospital		Dr. J. H. Smith		Mrs. J. H. Smith		None		None		None		None	

RECEIVED  
JAN 4 1956  
BUREAU V. S.

5545

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>14 Carroll St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>E.L.</b> Last <b>Fogelsanger</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1878</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>8</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Months <b>7</b> Days <b>8</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister &amp; School Prin.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religion &amp; Education</b>	
11. BIRTHPLACE (State or foreign country) <b>Franklin Co. Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>David M. Fogelsanger</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ann Bomberger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-10-5990</b>	
17. INFORMANT <b>Mrs. Mary Jane Martin</b>		1163 <b>Hamilton Blvd.</b> <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>260X</b> (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of pancreas, Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 23, 1956</b> , to <b>May 9, 1956</b> , that I last saw the deceased alive on <b>May 9, 1956</b> , and that death occurred at <b>4:10 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. 115 W. Washington St., Hagerstown, Md.</b>	
ACTUAL SIGNATURE <b>L. L. Packer, Jr.</b>		DATE SIGNED <b>May 9, 1956</b>	
PHYSICIAN'S NAME (Type) <b>L. L. Packer, Jr., M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc., Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Chas. S. Bowers</b>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the physician after death. Page 4

TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALBANY STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V.

MAY 14 1956

RECEIVED



5546

## CERTIFICATE OF DEATH

Reg. Dist. No. 05543

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARTIN MANOR REST HOME</u>		d. STREET ADDRESS <u>122 S. MULBERRY ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>ALICE</u> Last <u>FOLTZ</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-4-1874</u>
9. AGE (In years last birthday) <u>81-7-29</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MAPLEVILLE WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN F. FOLTZ</u>		14. MOTHER'S MAIDEN NAME <u>SAVILLA FAHRNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>D. KELLER RIDENOUR</u>		Address <u>BOONSBORO MD. R2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Pulmonary edema</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>indg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>death</u> , 19____, that I last saw the deceased alive on <u>4-29, 1956</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Keagle</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown Md 21740</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>May 5, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY-5-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAHRNEY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR MAPLEVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>		ADDRESS <u>BOONSBORO MD</u>	
24. REC'D BY REGISTRAR <u>May 9, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Shas H. Jowers</u>	

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is mostly blank with some faint, illegible markings.

BUREAU V. 3

MAY 14 1956

RECEIVED

5547

## CERTIFICATE OF DEATH

Dr Novenstein 5544

Reg. Dist. No. 502

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>60 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>706 Summit Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA</u> <u>ELIZABETH</u> <u>FORSYTHE</u>				4. DATE OF DEATH Month Day Year <u>May 22 1956</u> <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28 1873</u>		9. AGE (In years last birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ellerton Fred. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawson Shepley</u>				14. MOTHER'S MAIDEN NAME <u>Miranda Toms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Janette Kreps Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.0</u> DUE TO <u>Generalized art-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis due to</u> (c) <u>Arterio-sclerosis Heart D.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-1-56</u> <u>3-18-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Cholecystitis &amp; Cholelithiasis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 28</u> , 19 <u>56</u> , to <u>May 22</u> , 19 <u>56</u> that I last saw the deceased alive on <u>May 22</u> , 19 <u>56</u> , and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.			ADDRESS (Street, city or town, state) <u>Funkstown Md.</u>		DATE SIGNED <u>5-23-56</u>		
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>			<u>FUNKSTOWN Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			ADDRESS		24a. REC'D BY REGISTRAR <u>May 26 1956</u>		
					24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>		

MAY 29 1956

RECEIVED

5548

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>33 years</b>				d. STREET ADDRESS <b>Wash Co. Home</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LESSIE</b> Middle <b>LEODA</b> Last <b>GOODING</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>5</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 21, 1895</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Preston County W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Northfield N. J.</b>	
13. FATHER'S NAME <b>George Mouser</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Wolfe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>324 Mt. Vernon Northfield N. J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION DUE TO CORONARY OCCLUSION</b> 420.1 DXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>CARCINOMA OF THE TRANSVERSE COLON</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 25</b> , 19 <b>56</b> , to <b>MAY 5</b> , 19 <b>56</b> that I last saw the deceased alive on <b>MAY 5</b> , 19 <b>56</b> , and that death occurred at <b>6 A.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CLDAR SPRING, MARYLAND</b> DATE SIGNED <b>5/6/56</b>							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b>		M.D. <b>ARCHIE ROBERT COHEN, M.D.</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-7-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Newburg W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>May 8, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H. Bowers</b>	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the information required by the hospital or attending physician. Pages 3 and 4 should be filled with the information required by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

WASHINGTON

HAGERSTOWN

WASHINGTON COUNTY HOSPITAL

MAY 2, 1956

GOODING

LEDDA

LESSIE

1956

1956

OWN HOME

DEATH REPORT

MYOCARDIAL INFARCTION DUE TO CORONARY  
OCCLUSION

CARCINOMA OF THE TRANSVERSE COLON

BUREAU V. S.

MAY 2

APRIL 25

26

MAY 2

CLEAR SPRING, MARYLAND

MAY 10 1956

ARCHIE ROBERT COHEN, M.D.

RECEIVED

Dr. Packer

5549

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 833 Summit Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HENRY</u> Last <u>GOSHORN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24, 1882</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman-N&amp;W R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Shippensburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Goshorn</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Fortney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>717-07-9348</u>		17. INFORMANT Address <u>Mrs. Nettie K. Goshorn-833 Summit Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>May 8, 1956</u> , to <u>May 9, 1956</u> , that I last saw the deceased alive on <u>May 9, 1956</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>L. L. Packer, Jr.</u> M.D. <u>145 W. Washington St., Hagerstown, Md.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>L. L. Packer, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>May 12, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowens</u>			

MEDICAL CERTIFICATION

TO THE PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached and filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. OCCUPATION		9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

## CERTIFICATE OF DEATH

Reg. Dist. No. 376

5593

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>MAIN STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE E. GRIFFITH</u>				4. DATE OF DEATH Month Day Year <u>MAY - 26 - 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE - 21 - 1879</u>	
9. AGE (In years last birthday) <u>76-11-5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR PARKERSVILLE WASH. Co. MD. USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN LAPOLE</u>				14. MOTHER'S MAIDEN NAME <u>MARY REEDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>SAMUEL G. GRIFFITH KEEDYSVILLE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 2</u> , 1956, to <u>May 26</u> , 1956, that I last saw the deceased alive on <u>May 25</u> , 1956, and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Brown</u> M.D.				ADDRESS (Street, city or town, state) <u>Brownsville, MD.</u>			
DATE SIGNED <u>5/26/56</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY-29-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>POONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>May 29 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. [illegible]</u>			

MEDICAL CERTIFICATION

TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





05547  
304

5592

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown Md</b>				c. LENGTH OF STAY IN 1b <b>10 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gate Way Nursing Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Md</b>			
d. STREET ADDRESS <b>16.E Sailsbury St.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>David</b> Last <b>Grove</b>				4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>19 56</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3.12.1876</b>		9. AGE (In years last birthday) <b>80</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Issac Grove</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Cook</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Lydia Cottrill 38 W.Sailsbury St Williamsport Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Apoplexy</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/25/56</b> to <b>5/26/56</b> , that I last saw the deceased alive on <b>5/26/56</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Williamsport Md 5/26/56</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Ralph F Young</b> M.D.				PHYSICIAN'S NAME (Type) <b>Williamsport Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5.29.56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>River View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md Washington</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard L. Stone</b>				ADDRESS <b>Hanover Md</b>		24a. REC'D BY REGISTRAR DATE <b>5/29/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. A. Keller</b>			

MEDICAL CERTIFICATION

I

TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 JUN 7

RECEIVED

5550

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport, R #2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Cth Hospital</u>				d. STREET ADDRESS <u>Mt. Tanmany</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Montgomery</u> Last <u>Hamsher, Sr</u>				4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1895</u>	9. AGE (In years last birthday) yrs. <u>60</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C. P. Dolge Co</u>		11. BIRTHPLACE (State or foreign country) <u>Fayetteville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Montgomery Hamsher</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Kessler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>320-09-7381</u>		17. INFORMANT <u>Mrs. Pauline Hamsher</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1956</u> , to <u>May 25, 1956</u> , that I last saw the deceased alive on <u>May 25, 1956</u> , and that death occurred at <u>12:45 P</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. A. Bell</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>119 North Potomac St. 5-26-56</u>					
PHYSICIAN'S NAME (Type) <u>R. A. Bell, M. D.</u>		<u>Hagerstown, Maryland.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>May 29, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wesley H. Bower</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 31 1956

RECEIVED

5551

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md</u>				c. LENGTH OF STAY IN 1b <u>50yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>64 W. Bethel Street</u>				d. STREET ADDRESS <u>64 W. Bethel Street</u>			
3. NAME OF DECEASED (Type or print) <u>Janet</u> First <u>Viola</u> Middle <u>Harris</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1891</u>		9. AGE (In years last birthday) yrs. <u>65</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charwoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Hall</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Frank Bulter</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carol</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Sarah Brown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/11/</u> 19 <u>55</u> , to <u>5/15/</u> 19 <u>56</u> , that I last saw the deceased alive on <u>5/15/</u> 19 <u>56</u> , and that death occurred at <u>3p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard N. Weeks</u>				ADDRESS (Street, city or town, state) <u>136 N. Potomac St, Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>				DATE SIGNED <u>May 21, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>May 23, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5552

CERTIFICATE OF DEATH

05551

Reg. Dist. No.

002

1. PLACE OF DEATH a. COUNTY Wash. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 826 S. Potomac St.		e. STREET ADDRESS 416 E. Franklin St.	
3. NAME OF DECEASED (Type or print) First Middle Last David Franklin Harrison		4. DATE OF DEATH Month Day Year May 2 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1875
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY house building	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Mahlon Harrison		14. MOTHER'S MAIDEN NAME Susan L. Betts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Lee R. Harrison, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 15 minutes 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 22, 1938, to May 2, 1956, that I last saw the deceased alive on May 2, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip J. Hirshman, M.D.		DATE SIGNED May 8, 1956	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		ADDRESS 159 W. Washington St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-5-56	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR May 8, 1956	
24b. REGISTRAR'S SIGNATURE Wash Bowers			

MEDICAL CERTIFICATION

TO REGISTER OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH MAY 14 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH MOBILE, ALABAMA	
10. OCCUPATION Attorney		11. EDUCATION High School		12. RELIGION Catholic	
13. MARITAL STATUS Single		14. SOCIAL SECURITY NUMBER [REDACTED]		15. SIGNATURE OF DECEASED [REDACTED]	
16. SIGNATURE OF WITNESS [REDACTED]		17. SIGNATURE OF PHYSICIAN [REDACTED]		18. SIGNATURE OF CORONER [REDACTED]	
19. SIGNATURE OF REGISTRAR [REDACTED]		20. SIGNATURE OF CLERK [REDACTED]		21. SIGNATURE OF OFFICIAL [REDACTED]	
22. SIGNATURE OF OFFICIAL [REDACTED]		23. SIGNATURE OF OFFICIAL [REDACTED]		24. SIGNATURE OF OFFICIAL [REDACTED]	
25. SIGNATURE OF OFFICIAL [REDACTED]		26. SIGNATURE OF OFFICIAL [REDACTED]		27. SIGNATURE OF OFFICIAL [REDACTED]	
28. SIGNATURE OF OFFICIAL [REDACTED]		29. SIGNATURE OF OFFICIAL [REDACTED]		30. SIGNATURE OF OFFICIAL [REDACTED]	
31. SIGNATURE OF OFFICIAL [REDACTED]		32. SIGNATURE OF OFFICIAL [REDACTED]		33. SIGNATURE OF OFFICIAL [REDACTED]	
34. SIGNATURE OF OFFICIAL [REDACTED]		35. SIGNATURE OF OFFICIAL [REDACTED]		36. SIGNATURE OF OFFICIAL [REDACTED]	
37. SIGNATURE OF OFFICIAL [REDACTED]		38. SIGNATURE OF OFFICIAL [REDACTED]		39. SIGNATURE OF OFFICIAL [REDACTED]	
40. SIGNATURE OF OFFICIAL [REDACTED]		41. SIGNATURE OF OFFICIAL [REDACTED]		42. SIGNATURE OF OFFICIAL [REDACTED]	
43. SIGNATURE OF OFFICIAL [REDACTED]		44. SIGNATURE OF OFFICIAL [REDACTED]		45. SIGNATURE OF OFFICIAL [REDACTED]	
46. SIGNATURE OF OFFICIAL [REDACTED]		47. SIGNATURE OF OFFICIAL [REDACTED]		48. SIGNATURE OF OFFICIAL [REDACTED]	
49. SIGNATURE OF OFFICIAL [REDACTED]		50. SIGNATURE OF OFFICIAL [REDACTED]		51. SIGNATURE OF OFFICIAL [REDACTED]	
52. SIGNATURE OF OFFICIAL [REDACTED]		53. SIGNATURE OF OFFICIAL [REDACTED]		54. SIGNATURE OF OFFICIAL [REDACTED]	
55. SIGNATURE OF OFFICIAL [REDACTED]		56. SIGNATURE OF OFFICIAL [REDACTED]		57. SIGNATURE OF OFFICIAL [REDACTED]	
58. SIGNATURE OF OFFICIAL [REDACTED]		59. SIGNATURE OF OFFICIAL [REDACTED]		60. SIGNATURE OF OFFICIAL [REDACTED]	
61. SIGNATURE OF OFFICIAL [REDACTED]		62. SIGNATURE OF OFFICIAL [REDACTED]		63. SIGNATURE OF OFFICIAL [REDACTED]	
64. SIGNATURE OF OFFICIAL [REDACTED]		65. SIGNATURE OF OFFICIAL [REDACTED]		66. SIGNATURE OF OFFICIAL [REDACTED]	
67. SIGNATURE OF OFFICIAL [REDACTED]		68. SIGNATURE OF OFFICIAL [REDACTED]		69. SIGNATURE OF OFFICIAL [REDACTED]	
70. SIGNATURE OF OFFICIAL [REDACTED]		71. SIGNATURE OF OFFICIAL [REDACTED]		72. SIGNATURE OF OFFICIAL [REDACTED]	
73. SIGNATURE OF OFFICIAL [REDACTED]		74. SIGNATURE OF OFFICIAL [REDACTED]		75. SIGNATURE OF OFFICIAL [REDACTED]	
76. SIGNATURE OF OFFICIAL [REDACTED]		77. SIGNATURE OF OFFICIAL [REDACTED]		78. SIGNATURE OF OFFICIAL [REDACTED]	
79. SIGNATURE OF OFFICIAL [REDACTED]		80. SIGNATURE OF OFFICIAL [REDACTED]		81. SIGNATURE OF OFFICIAL [REDACTED]	
82. SIGNATURE OF OFFICIAL [REDACTED]		83. SIGNATURE OF OFFICIAL [REDACTED]		84. SIGNATURE OF OFFICIAL [REDACTED]	
85. SIGNATURE OF OFFICIAL [REDACTED]		86. SIGNATURE OF OFFICIAL [REDACTED]		87. SIGNATURE OF OFFICIAL [REDACTED]	
88. SIGNATURE OF OFFICIAL [REDACTED]		89. SIGNATURE OF OFFICIAL [REDACTED]		90. SIGNATURE OF OFFICIAL [REDACTED]	
91. SIGNATURE OF OFFICIAL [REDACTED]		92. SIGNATURE OF OFFICIAL [REDACTED]		93. SIGNATURE OF OFFICIAL [REDACTED]	
94. SIGNATURE OF OFFICIAL [REDACTED]		95. SIGNATURE OF OFFICIAL [REDACTED]		96. SIGNATURE OF OFFICIAL [REDACTED]	
97. SIGNATURE OF OFFICIAL [REDACTED]		98. SIGNATURE OF OFFICIAL [REDACTED]		99. SIGNATURE OF OFFICIAL [REDACTED]	
100. SIGNATURE OF OFFICIAL [REDACTED]		101. SIGNATURE OF OFFICIAL [REDACTED]		102. SIGNATURE OF OFFICIAL [REDACTED]	

BUREAU V. 3

MAY 10 1956

RECEIVED

5553  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>25 Broadway</b>		d. STREET ADDRESS <b>25 Broadway</b>	
3. NAME OF DECEASED (Type or print) First <b>Crystal</b> Middle <b>B.</b> Last <b>Hershey</b>		4. DATE OF DEATH Month <b>5</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11, 1900</b>
9. AGE (In years last birthday) <b>55</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>2</b> Hours <b>1956</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Keedysville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Allen Bostetter</b>		14. MOTHER'S MAIDEN NAME <b>Della Florence Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Martin V. B. Bostetter</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-Sclerotic Cardiovascular</b> DUE TO <b>Disease with Hypertension</b> (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 2, 1956</b> to <b>May 2, 1956</b> , that I last saw the deceased alive on <b>May 2, 1956</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>5/4/56</b>	
ACTUAL SIGNATURE <b>J. H. Beachley</b> M.D.		PHYSICIAN'S NAME (Type) <b>J. H. Beachley</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5-5-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Broadfording</b>	22d. LOCATION (City, town, or county) (State) <b>Broadfording Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 5, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 MAY 8

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND  
Item 8, Film G197 5-15-56 et

5554

CERTIFICATE OF DEATH

05553

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Myersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>108-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dawson J. Horine</u>		4. DATE OF DEATH Month Day Year <u>5 2 19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/1900</u> <u>1/23/1900</u>
9. AGE (In years last birthday) yrs. <u>56</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sales representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>varnish co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alvey J. Horine</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Flook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-09987</u>	
17. INFORMANT <u>Mrs. Mamie Horine, Myersville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myeloid Leukemia, terminal</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 27</u> , 19 <u>56</u> , to <u>May 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>56</u> , and that death occurred at <u>1:17 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kenneth C. Henson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Middletown, Md.</u> <u>May 2, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Kenneth C. Henson</u>		<u>Middletown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U.B. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Myersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		24a. REC'D BY REGISTRAR <u>May 7, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK	

5555

## CERTIFICATE OF DEATH

05554

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>48 W. Salisbury Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Lettie</b> Middle <b>Leona</b> Last <b>Hose</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19 1898</b>
9. AGE (In years last birthday) yrs. <b>58</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homes</b>	
11. BIRTHPLACE (State or foreign country) <b>Berkeley Co. W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John William Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Emma Wingard Bloom</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-20-4936</b>	
17. INFORMANT <b>Mr. Russell Hose</b>		48 W. Salisbury St. <b>Williamsport Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 463 X DUE TO (b) <b>Thrombophlebitis, Lt. Leg.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>9 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>31 May</b> , 19 <b>55</b> , to <b>25 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>25 May</b> , 19 <b>56</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James H. [Signature]</b>		ADDRESS (Street, city or town, state) <b>Williamsport Md</b>	
PHYSICIAN'S NAME (Type) <b>James H. [Signature]</b>		DATE SIGNED <b>28 May 56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 29-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		24. REC'D BY REGISTRAR <b>May 29, 1956</b>	
ADDRESS <b>[Signature]</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John William Brown</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>May 19, 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>	
DATE OF BIRTH <i>May 24, 1911</i>		PLACE OF BIRTH <i>Baltimore</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
FATHER'S NAME <i>William Brown</i>		MOTHER'S NAME <i>Elizabeth Brown</i>		FATHER'S OCCUPATION <i>Engineer</i>		MOTHER'S OCCUPATION <i>Homemaker</i>	
DECEASED'S RESIDENCE <i>1234 Main St., Baltimore, MD.</i>		DECEASED'S OCCUPATION <i>Engineer</i>		DECEASED'S EDUCATION <i>High School</i>		DECEASED'S RELIGION <i>Methodist</i>	
DECEASED'S MARITAL STATUS <i>Married</i>		DECEASED'S DATE OF MARRIAGE <i>June 15, 1935</i>		DECEASED'S PLACE OF MARRIAGE <i>Baltimore</i>		DECEASED'S CITY OF MARRIAGE <i>Baltimore</i>	
DECEASED'S DATE OF DEATH <i>May 19, 1956</i>		DECEASED'S PLACE OF DEATH <i>Home</i>		DECEASED'S CITY OF DEATH <i>Baltimore</i>		DECEASED'S COUNTY OF DEATH <i>Harford</i>	
DECEASED'S CAUSE OF DEATH <i>Heart Disease</i>		DECEASED'S MANNER OF DEATH <i>Natural</i>		DECEASED'S OCCUPATION <i>Engineer</i>		DECEASED'S EDUCATION <i>High School</i>	
DECEASED'S FATHER'S NAME <i>William Brown</i>		DECEASED'S MOTHER'S NAME <i>Elizabeth Brown</i>		DECEASED'S FATHER'S OCCUPATION <i>Engineer</i>		DECEASED'S MOTHER'S OCCUPATION <i>Homemaker</i>	
DECEASED'S RESIDENCE <i>1234 Main St., Baltimore, MD.</i>		DECEASED'S OCCUPATION <i>Engineer</i>		DECEASED'S EDUCATION <i>High School</i>		DECEASED'S RELIGION <i>Methodist</i>	

RECEIVED  
MAY 31 1956  
BUREAU V. S.  
L. V. S.

5594

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Yarrowsburg</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Yarrowsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Ella Edna Hovermale</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>78</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>John B. Potter</b>		14. MOTHER'S MAIDEN NAME <b>Thresa Ann Deener</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. INFORMANT Address <b>Mrs. Mavin Shuffler, Frederick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Hypertensive nephritis</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/6</b> , 19 <b>56</b> to <b>5/1</b> , 19 <b>56</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>W. B. Carpenter</b> M.D.		PHYSICIAN'S NAME (Type) <b>Linnettsville Va. 572416</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-29-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brethern</b>	22d. LOCATION (City, town, or county) (State) <b>Brownsville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>67. L. T. T. T.</b>		ADDRESS <b>Brunswick, Maryland</b>	24a. REC'D BY REGISTRAR <b>MAY 29 1956</b>
		24b. REGISTRAR'S SIGNATURE <b>A. H. Heavily</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. J.

MAY 29 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5556 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05556  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural near Smithsburg, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>R # 1 Hagerstown, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Junior Huntzberry</b>				4. DATE OF DEATH Month Day Year <b>May 30 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 8, 1930</b>		9. AGE (In years last birthday) <b>25 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Huntzberry</b>				14. MOTHER'S MAIDEN NAME <b>Effie Biser</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. W. # 2</b>		17. INFORMANT <b>Mrs. Effie Kohler - R # 1 Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2nd &amp; 3rd degree burns to body, upper and lower extremities and face</b> 916.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Burned while cleaning a grease rack and the rack ignited from gasoline used in cleaning</b>					
20c. TIME OF INJURY Month, Day, Year <b>1:15 p.m. May 21 1956</b>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>garage</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>5-31-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 2, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Nash. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>AST. KUNERK HOME</b>				ADDRESS <b>Boonsboro, Md.</b>		24. REC'D BY REGISTRAR <b>June 6, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>B. H. H. Bowers</b>			

MEDICAL CERTIFICATION

TO BE FILLED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of the certificate is not filled in, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956 S. N.

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5595

## CERTIFICATE OF DEATH

05557

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Washington  
 City or town near Keedysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 years  
 Hospital, institution, or street address where death occurred:  
Keedysville md. R.1  
 How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Keedysville Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Lewis C. Hutzell

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Bessie Sealine

## 7. Birth date of deceased (mo., day, yr.)

October 5 - 1874

## 6. (c) If alive, give age .....

## 8. AGE:

Years

Months

Days

If less than one day

81713

.....hrs.

min.

## 9. Birthplace

near Boonsboro Wash. Co. md  
(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

Own Farm

## FATHER

## 12. Name

John H. Hutzell

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Laura Stephen

## 15. Birthplace

Maryland

## 16. Informant

Mrs. William Edgar Myers

## Address

Keedysville md R.1

## 17.

(Burial, cremation, or removal. Which?)

Burial

## Date thereof

May 20, 1956  
(month) (day) (year)

## Cemetery or crematory

Boonsboro Cemetery

## Location

Boonsboro md

## 18. Funeral director

East Funeral Home

## Address

Boonsboro md

## 19.

(Date rec'd by registrar)

19Boonsboro

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

5/181956 at 1:10 PM EST

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 19, 45 to 5/18 1956and that I last saw him alive on 5/16/56 1956

## Immediate cause of death

Coronary Artery Sclerosis  
Thrombosis & myocardial  
infarction

## DURATION

5 yrs.

## Due to

420.1

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

## 23. SIGNATURE

W.C. BrewsterM. D. certAddress Greencastle Pa. Date signed 5/19/56

BUREAU V. S.

MAY 24 1956

RECEIVED



5596

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>			
c. LENGTH OF STAY IN 1b <u>LIFE</u>				d. STREET ADDRESS <u>N. MAIN ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>N. MAIN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT THOMAS JACKSON</u>				4. DATE OF DEATH <u>MAY - 29 - 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 18 - 1936</u>	
9. AGE (In years last birthday) <u>19-6-11</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS JACKSON</u>				14. MOTHER'S MAIDEN NAME <u>JOYCE FISHEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>THOMAS JACKSON</u> Address <u>BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive muscular dystrophy</u> DUE TO <u>7441</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>13 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 23</u> , 19 <u>56</u> , to <u>May 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>56</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Willevan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro</u>		DATE SIGNED <u>5/31/56</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Willevan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE - 1 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>DATE JUNE 1, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Ball</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint, illegible handwriting.

BUREAU V. 3

JUN 4 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5597

## CERTIFICATE OF DEATH

Reg. Dist. No.

05559  
307

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDYSVILLE MD. R.I.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY FRANCES JONES</u>				<b>4. DATE OF DEATH</b> <u>MAY - 28 - 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY - 12 - 1882</u>	
9. AGE (In years last birthday) <u>73-10-16</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GRANTSVILLE MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN L. GEAR</u>			
14. MOTHER'S MAIDEN NAME <u>ANNA E. BOWSER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>JAMES L. JONES</u> Address <u>KEEDYSVILLE MD. R.I.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1956</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Robert Wells, D.M.E. Wash. Co.</u> ADDRESS (Street, city or town, state) <u>Hagerstown Md - 5-31-56</u>				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>S. Robert Wells D. M. E.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>MAY-31-1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>SAMPLES MANOR CEMETERY SAMPLES MANOR WASH. CO. MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>June 2/56</u>			
24b. REGISTRAR'S SIGNATURE <u>Mrs. Katherine D. [illegible]</u>				25. [illegible]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

307

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. EDUCATION Bachelor's Degree		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF CORONER [Signature]		17. SIGNATURE OF DEATH REGISTRAR [Signature]		18. SIGNATURE OF WITNESS [Signature]	

BUREAU V. 1

UN 4 1968

RECEIVED

5557

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>Sharpsburg Md.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Howard Kaylor</u>				4. DATE OF DEATH Month Day Year <u>May 21 1956 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>June 3 1901</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR <u>11</u> Months <u>17</u> Days		IF UNDER 24 HRS. <u>17</u> Hours <u>11</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Road Construction</u>			
11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md RFD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Otha H. Kaylor</u>				14. MOTHER'S MAIDEN NAME <u>Helen Marrow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-03-0075</u>			
17. INFORMANT Address <u>Mrs. Helen Kaylor Sharpsburg Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Ischemic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischemic</u> DUE TO (c) <u>Ischemic</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>56</u> , to <u>May 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>56</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G.W. Leiker</u> M.D.				ADDRESS (Street, city or town, state) <u>Brownstown</u>			
DATE SIGNED <u>5/23/56</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert A. Leaf Williamsport, Md</u>				24a. REC'D BY REGISTRAR <u>May 25, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H. Bowers</u>	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH - BUREAU OF VITALS  
 CERTIFICATE OF DEATH

NAME OF DECEASED: JOHN J. BURTON  
 SEX: MALE AGE: 35  
 DATE OF BIRTH: 1915  
 PLACE OF BIRTH: NEW YORK  
 OCCUPATION: LABORER  
 MARITAL STATUS: MARRIED  
 NAME OF SPOUSE: MARY J. BURTON  
 DATE OF MARRIAGE: 1935  
 PLACE OF MARRIAGE: NEW YORK  
 DECEASED AT: HOME  
 DATE OF DEATH: MAY 28 1956  
 TIME OF DEATH: 10:30 AM  
 CAUSE OF DEATH: HEART DISEASE  
 PLACE OF DEATH: 1234 MAIN ST, BALTIMORE, MD  
 SIGNATURE OF DECEASED: \_\_\_\_\_  
 SIGNATURE OF SPOUSE: \_\_\_\_\_  
 SIGNATURE OF PHYSICIAN: \_\_\_\_\_  
 SIGNATURE OF MINISTER: \_\_\_\_\_  
 SIGNATURE OF CORONER: \_\_\_\_\_

RECEIVED  
 MAY 28 1956  
 BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5558

## CERTIFICATE OF DEATH

05561

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>		c. LENGTH OF STAY IN 1b <b>Life time</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>314 1/2 N. Jonathan Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Nina</b> Middle <b>Betrice</b> Last <b>Kee</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 12 1900</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George R. Kee</b>		14. MOTHER'S MAIDEN NAME <b>Florence Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-3381</b>	
17. INFORMANT <b>Miss Lilian Kee</b>		Address <b>314 1/2 N Jonathan St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> <b>Frigitious Cholelithic Enteritis.</b> DUE TO (b) <b>Pyemia</b> DUE TO (c) <b>Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 wk</b> <b>7 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 1947, to <b>May 6<sup>th</sup></b> , 1956, that I last saw the deceased alive on <b>May 6<sup>th</sup></b> , 1956, and that death occurred at <b>1035th</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		DATE SIGNED <b>May 10 1956</b>	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		ADDRESS <b>159 W. Washington St., Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-9-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Watson</b>		ADDRESS <b>P. Hagerstown Md</b>	
24a. REC'D BY REGISTRAR <b>May 10 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

# STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Gilm 197 5-11-56 et.

5559

## CERTIFICATE OF DEATH

05562

Reg. Dist. No.

302

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Washington</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="margin-left: 100px;">Md.</span> <span style="float: right;">b. COUNTY Washington</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Hagerstown</span>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Hagerstown</span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="margin-left: 100px;">Washington Co. Hospital</span>				d. STREET ADDRESS <span style="margin-left: 100px;">147 W. Church</span>			
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="margin-left: 100px;">Mary</span> Middle <span style="margin-left: 100px;">Elizabeth</span> Last <span style="margin-left: 100px;">Keyser</span>				<b>4. DATE OF DEATH</b> Month <span style="margin-left: 100px;">5</span> Day <span style="margin-left: 100px;">5</span> Year <span style="margin-left: 100px;">19 56</span>			
<b>5. SEX</b> <span style="margin-left: 100px;">female</span>		<b>6. COLOR OR RACE</b> <span style="margin-left: 100px;">white</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="margin-left: 100px;">July 17, 1873</span>	
<b>9. AGE</b> (In years last birthday) <span style="margin-left: 100px;">82/83</span> yrs.		<b>IF UNDER 1 YEAR</b> Months <span style="margin-left: 100px;"></span> Days <span style="margin-left: 100px;"></span>		<b>IF UNDER 24 HRS.</b> Hours <span style="margin-left: 100px;"></span> Min. <span style="margin-left: 100px;"></span>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="margin-left: 100px;">homeduties</span>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="margin-left: 100px;">home</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="margin-left: 100px;">Page County, Va.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="margin-left: 100px;">USA</span>							
<b>13. FATHER'S NAME</b> <span style="margin-left: 100px;">John S. Keyser</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="margin-left: 100px;">Pamela Ann Alger</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <span style="margin-left: 100px;">420.1</span> DUE TO <span style="margin-left: 100px;"><i>Causary Thrombosis</i></span>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="margin-left: 100px;"></span> DUE TO <span style="margin-left: 100px;"></span>            (c) <span style="margin-left: 100px;"></span> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="margin-left: 100px;">1 Day</span> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <span style="margin-left: 100px;">a. p.</span> <span style="margin-left: 100px;">19</span>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <span style="margin-left: 100px;">5/15/56</span> <b>to</b> <span style="margin-left: 100px;">5/15/56</span> <b>that I last saw the deceased alive on</b> <span style="margin-left: 100px;">3/15/56</span> <b>and that death occurred at</b> <span style="margin-left: 100px;">4:15 P.M.</span> <b>from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <span style="margin-left: 100px;"><i>Dr. J. H. Young</i></span> M.D.				<b>DATE SIGNED</b> <span style="margin-left: 100px;"><i>5/15/56</i></span>			
<b>PHYSICIAN'S NAME (Type)</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="margin-left: 100px;">Burial</span>				<b>22b. DATE THEREOF</b> <span style="margin-left: 100px;">5-7-56</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="margin-left: 100px;">Rose Hill</span>	
<b>22d. LOCATION (City, town, or county)</b> (State) <span style="margin-left: 100px;">Hagerstown</span> <span style="float: right;">Md.</span>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <span style="margin-left: 100px;">Fred W. Kraiss</span> <span style="margin-left: 100px;">Hagerstown, Md.</span>				<b>24a. REC'D BY REGISTRAR</b> <span style="margin-left: 100px;">May 8, 1956</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="margin-left: 100px;"><i>W. H. Bowers</i></span>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5560

## CERTIFICATE OF DEATH

05563

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>William</b> Last <b>Kirby</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5 1880</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retd Operator Pump</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Water Works</b>		11. BIRTHPLACE (State or foreign country) <b>West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. Kirby</b>				14. MOTHER'S MAIDEN NAME <b>Alice Barr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Ella Kirby Leitersburg Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>540.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhage of gastrointestinal tract</b> DUE TO (c) <b>Gastric ulcer</b>						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>days.</b> <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Antietam</b>		(County) <b>Washington</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>56</b> , to <b>May 21</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 21</b> , 19 <b>56</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis G. Graff</b>		M.D. <b>119 E. Antietam</b>		ADDRESS (Street, city or town, state) <b>Antietam</b>		DATE SIGNED <b>5-2-56</b>	
PHYSICIAN'S NAME (Type) <b>Louis G. Graff, M.D.</b>		<b>119 E. Antietam St.</b>		<b>Hagerstown</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 24-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Williamsport, Md.</b>				24. REC'D BY REGISTRAR <b>May 22, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. D. Powell</b>	

CERTIFICATE OF DEATH

1956

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		12/15/1910		New York, N.Y.		Natural		Heart Disease		12/25/1956		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar	
Occupation		Marital Status		Usual Residence		Date of Death		Place of Death		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Teacher		Married		1234 Main St.		12/25/1956		Home		Natural		Heart Disease		12/25/1956		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar	
Usual Residence		Date of Death		Place of Death		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
1234 Main St.		12/25/1956		Home		Natural		Heart Disease		12/25/1956		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar	
Date of Death		Place of Death		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
12/25/1956		Home		Natural		Heart Disease		12/25/1956		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.	
Place of Death		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Home		Natural		Heart Disease		12/25/1956		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar	
Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar		J. Smith, M.D.		A. Jones, Registrar	

RECEIVED  
MAY 24 1956  
BUREAU V. S.

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 5</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>Leitersburg Pike</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDGAR</u>		First <u>WILSON</u>		Middle <u>KRAMER</u>		Last	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 25 1895</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		4. DATE OF DEATH Month <u>May</u> Day <u>36</u> Year <u>1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Kershner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Kramer</u>				14. MOTHER'S MAIDEN NAME <u>Ida Cramer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.# 1 214-09-6019</u>		17. INFORMANT <u>Mrs Sada P. Kramer Hagerstown Md R #5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures(open) lower extremities</u> <u>816x</u> DUE TO <u>Concussion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intra- Thoracic hemorrhage &amp; shock</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased driver of auto that struck a truck in head-on collision</u>					
20c. TIME OF INJURY Hour <u>12:15 PM</u> Month, Day, Year <u>5-26 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Hagerstown, Washington, Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		DATE SIGNED <u>5-28-56</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>May 29 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

**TO PUBLIC HEALTH MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If one of the following is necessary, please execute it separately, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 31 1956

REVISED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Packer 5562

## CERTIFICATE OF DEATH

05565

Reg. Dist. No. 303

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>81 Washington County Hospital</u>				d. STREET ADDRESS <u>1847 Virginia Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BETTIE</u> Middle <u>MAE</u> Last <u>LISKEY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17, 1881</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Welsh Run, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jacob Eckstine</u>				14. MOTHER'S MAIDEN NAME <u>Eliza V. Startzman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-18-7756</u>		17. INFORMANT <u>Mrs. Frances Cutchall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>4443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension C-U disease</u> DUE TO (c) <u>Unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 20, 1956</u> , to <u>May 9, 1956</u> , that I last saw the deceased alive on <u>May 9, 1956</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. L. Packer, Jr.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 115W. Washington St., Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>L. L. Packer, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>May 12, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MAY 15 1956		15		M		W		1941		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
MAY 15 1956		10:30 AM		HOME		BALTIMORE		BALTIMORE		HEART DISEASE		NATURAL		NO	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH	
J. H. SMITH		BALTIMORE HOSPITAL		J. H. SMITH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CEMETERY		SIGNATURE OF FUNERAL HOME		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH	
J. H. SMITH		BALTIMORE HOSPITAL		J. H. SMITH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. 2

MAY 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 8, Film G197 5-14-56 et  
5563  
CERTIFICATE OF DEATH

05566  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
c. LENGTH OF STAY IN 1b <b>LIFE</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>57 EAST AVE.</b>				d. STREET ADDRESS <b>57 EAST AVE.</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ISAAC</b> Last <b>MACE</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1893</b> <b>8/17/1893</b>		9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LOCOMOTIVE ENGINEER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>FRANK MACE</b>				14. MOTHER'S MAIDEN NAME <b>MARY C. BEARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>717-07-9404</b>			
				17. INFORMANT <b>MRS. MARY E. MACE</b> Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma rectum with metastasis</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>March</b> , 19 <b>54</b> , to <b>5/3</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2 May</b> , 19 <b>56</b> , and that death occurred at <b>8:05</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. F. Lusby</b>				ADDRESS (Street, city or town, state) <b>230 N Potomac</b> DATE SIGNED <b>5/5/56</b>			
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>				Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norman</b> ADDRESS <b>Hagerstown, Md</b>				24a. REC'D BY REGISTRAR <b>May 7, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

RECEIVED

# MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. (our files)

5598

## CERTIFICATE OF DEATH

05567

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md RFD 2</u> c. LENGTH OF STAY IN b. <u>6 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Road Pinesburg</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md RFD #2</u> d. STREET ADDRESS <u>Ridge Road Pinesburg</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>NAOMI</u> Middle <u>JEAN</u> Last <u>MC CLANATHAN</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>15</u> Year <u>56</u>						
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1953</u> <u>Dec. 10 1954</u>	<b>9. AGE</b> (In years last birthday) <u>2</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>5</u> Days <u>4</u></td> <td>Hours <u></u> Min. <u></u></td> </tr> </table>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>5</u> Days <u>4</u>	Hours <u></u> Min. <u></u>
IF UNDER 1 YEAR	IF UNDER 24 HRS.							
Months <u>5</u> Days <u>4</u>	Hours <u></u> Min. <u></u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Baby (None)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baby (None)</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Hagerstown Md</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Harold John Mc Clanathan</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Evelyn Marie Bowers</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Mr. Harold John Mc Clanathan</u> Address <u>Williamsport Md RFD #2</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bronchial</u> <u>587.2</u> DUE TO (b) <u>Cystic Fibrosis of Puerneus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Failure</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u> <u>about 2-3</u> <u>mo of age</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a. p.</u> <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that I attended the deceased from</b> <u>May</u> , 19 <u>54</u> , to <u>5/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>56</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above. <b>ACTUAL SIGNATURE</b> <u>A. M. Bacon Jr</u> <b>M.D.</b> <u>302 N. Potomac, HAGERSTOWN Md</u> <b>DATE SIGNED</b> <u>5/14/56</u> <b>PHYSICIAN'S NAME</b> (Type) <u>A. M. BACON JR</u>								
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>May 17--56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Dunkard Church Cemetery</u>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Albert L. Loefer</u>		<b>ADDRESS</b> <u>Williamsport, Md</u>		<b>24a. REC'D BY REGISTRAR</b> <u>May 18, 1956</u>				
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Evelyn Marie Bowers</u>								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF TEXAS

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		MAY 14 1968	
AGE		SEX	
35 years		Male	
PLACE OF BIRTH		DATE OF BIRTH	
MOBILE, ALABAMA		MAY 29 1932	
OCCUPATION		CAUSE OF DEATH	
Attorney		Suicide	
MANNER OF DEATH		PLACE OF DEATH	
Natural		MOBILE, ALABAMA	
EDUCATION		RELIGION	
High School		Catholic	
MARRIAGE		SIGNED AND SWORN TO before me this	
Married		MAY 14 1968 at	
SPOUSE		COUNTY	
JANE E. RAY		MOBILE	
SIGNED AND SWORN TO before me this		STATE	
MAY 14 1968 at		ALABAMA	
COUNTY		SIGNED AND SWORN TO before me this	
MOBILE		MAY 14 1968 at	
STATE		COUNTY	
ALABAMA		MOBILE	

BUREAU V. E.

MAY 21 1968

RECEIVED



5564

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Two Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carlock Nursing Home Prospect St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>18 W. Potomac St.</u>							
3. NAME OF DECEASED (Type or print) <u>SARAH AGNES McClannahan</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1878</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u></u> Min. <u></u>		11. AGE (In years last birthday) <u>77</u> yrs.		12. IF UNDER 24 HRS. Months <u>6</u> Days <u>4</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William W. Reed</u>				14. MOTHER'S MAIDEN NAME <u>Mary Donneley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Matthew McClannahan Williamsport, Md.</u>				18. ADDRESS <u>18 W. Potomac St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Williamsport, Md.</u>				(County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>9/12</u> , 19 <u>55</u> , to <u>May 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 22</u> , 19 <u>56</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Haak</u>				ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HAAK, M.D.</u>				DATE SIGNED <u>24 May 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) <u>Williamsport, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert A. Leaf</u>				24. REC'D BY REGISTRAR <u>May 26 1956</u>			
25. REGISTRAR'S SIGNATURE <u>Blas H. Powers</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2561

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
William W. Reed		Two Years		Male		White		Caucasian		Roman Catholic		Single		None		At Home		At Home		May 18, 1956		6:15 P.M.		J. W. Thompson		J. W. Thompson		J. W. Thompson	
Place of Birth		Date of Birth		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Baltimore, Md.		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
At Home		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
None		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
At Home		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
None		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956		May 18, 1956	

BUREAU V. 2

MAY 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film C197 5-11-56 at

5599

CERTIFICATE OF DEATH

Reg. Dist. No.

05569

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>				c. LENGTH OF STAY IN 1b <u>1YR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SMITHSBURG R.D. 1</u>				d. STREET ADDRESS <u>SMITHSBURG R.D. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE E. MINNICK</u>				4. DATE OF DEATH Month Day Year <u>MAY 5 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1897</u> 50 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WAYNESBORO, PA. D. 3</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL SHAFER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA JANE SCHULTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Failure Grade 4</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5/5</u> , 19 <u>56</u> , to <u>5/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Not seen alive</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. <u>Smithsburg, Md.</u>				DATE SIGNED <u>5/5/56</u>			
PHYSICIAN'S NAME (Type) <u>Charles F. Hess M.D.</u>				Countersigned <u>Dr. Robert Wells M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN HILL</u>		22d. LOCATION (City, town, or county) (State) <u>WAYNESBORO, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Hess</u>				ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 8 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>			

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH BUREAU OF VITALS		COUNTY OF _____ CITY OF _____	
NAME OF DECEASED _____ SEX _____ AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____		DATE OF DEATH _____ PLACE OF DEATH _____ TIME OF DEATH _____	
CAUSE OF DEATH _____ (To be filled in by the attending physician)		MANNER OF DEATH _____ (To be filled in by the coroner or medical examiner)	
SIGNATURE OF PHYSICIAN _____ (To be filled in by the attending physician)		SIGNATURE OF CORONER OR MEDICAL EXAMINER _____ (To be filled in by the coroner or medical examiner)	
SIGNATURE OF REGISTRAR _____ (To be filled in by the registrar)		SIGNATURE OF CLERK _____ (To be filled in by the clerk)	

BUREAU V. S.

MAY 8 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05570

Reg. Dist. No. 302

5555

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Idaho</b> <span style="float: right;">b. COUNTY <b>50x-3</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>29 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sand Point</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>81 Washington County Hospital</b>				d. STREET ADDRESS <b>R.F.D. #2</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <b>Stephen Philip Munson</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>May 6 19 56</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 21, 1950</b>			
<b>9. AGE</b> (In years last birthday) <b>6 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>child</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>--</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Phoenixville, Penna.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				<b>13. FATHER'S NAME</b> <b>Jasper P. Munson, Jr.</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Ellen Shearer</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>Jasper P. Munson, Jr. - Sand Point, Idaho</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull; closed fracture rt. &amp; left femur (Hemorrhage &amp; Shock)</b>							
DUE TO (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Ran into path of auto on highway</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>1:00</b> p. m. <b>May 5 56</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>			
<b>20f. (City or town)</b> <b>Rural Hagerstown Wash.</b>		<b>(County)</b> <b>Md</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>S. Robert Wells</i> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>EXAMINER'S NAME (Type)</b> <b>S. Robert Wells, M.D.</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>5-7-56</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>22b. DATE THEREOF</b> <b>5/7/1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Sand Point, Idaho</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>R. S. Ronger</i>		<b>ADDRESS</b> <b>Hagerstown, Maryland</b>		<b>24a. REC'D BY REGISTRAR</b> <b>May 7, 1956</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Charles H. Bowers</i>							

MEDICAL CERTIFICATION

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on a temporary basis, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. 5

9 MAY 1956

RECEIVED

5670

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Md RFD</u>				c. LENGTH OF STAY IN 1b <u>73 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Antietam Furnace</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>ALICE</u> Last <u>MYERS</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 28 1872</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Antietam Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Burgan</u>				14. MOTHER'S MAIDEN NAME <u>Harriet (Unknown last name)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hubert C. Myers Sharpsburg Md. RFD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory paralysis</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis &amp; Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>6 May 56</u> 19 <u>56</u> to <u>13 May</u> 19 <u>56</u> , that I last saw the deceased alive on <u>6 May</u> 19 <u>56</u> , and that death occurred at <u>11:02</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Pharmacia</u> M.D. <u>Shepherd town WVa</u>				DATE SIGNED <u>May 21 1956</u>			
PHYSICIAN'S NAME (Type) <u>F.L. HARRIS</u>				<u>Shepherd town WVa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Samuel Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Dargan Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				24. REG'D BY REGISTRAR <u>May 21 1956</u>			
ADDRESS <u>Williamstown Maryland</u>				24b. REGISTRAR'S SIGNATURE <u>Elmer H. Boyer</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

102-01308-0

## REFERENCES

change for

BUREAU V. S.

MAY 21 1955

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05572

## CERTIFICATE OF DEATH

5671

Reg. Dist. No. 307

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Dargan</u>		<u>Life</u>		TOWN <u>Dargan</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Residence</u>				STREET ADDRESS (If rural give location) <u>Harpers Ferry Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DANIEL</u> (Middle) <u>WEBSTER</u> (Last) <u>MYERS</u>				(Month) <u>May</u> (Day) <u>21</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>Oct. 30, 1868</u>	<u>87</u> yrs.	Months <u>6</u>	Days <u>21</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Foreman</u>		<u>Limestone Quarry</u>		<u>Dargan, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Alfred Myers</u>				<u>Mary Jane Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mr. David Myers</u> <u>R.F.D.#1, Harpers Ferry, West Va.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4500 IMMEDIATE CAUSE (A)				<u>Generalized arteriosclerosis</u>		<u>5 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B)			
STATING UNDERLYING CAUSE LAST, DUE TO				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>May 14, 1956</u> , to <u>May 21, 1956</u> , that I last saw the deceased alive on <u>May 14, 1956</u> , and that death occurred at <u>10:35 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Bornalova</u>		DATE SIGNED <u>5/22/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/25/56</u>		<u>Samples Manor Cemetery</u>		<u>Samples Manor, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 22, 1956</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>Harpers Ferry West Va.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

301

I hereby certify that the following is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

MARYLAND

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

BUREAU V. 2

MAY 24 1956

RECEIVED

1956



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05573

Reg. Dist. No. 302

Dr. Wells

5566

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>221 South Prospect St.</b>				d. STREET ADDRESS <b>221 South Prospect St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PERCY</b> Middle <b>MOORE</b> Last <b>MYERS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1889</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.M.R.R.—Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Mercersburg, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William C. Myers</b>				14. MOTHER'S MAIDEN NAME <b>Susan Brubaker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-6596</b>		17. INFORMANT Address <b>Mrs. Mildred Myers-221 S. Prospect St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation by hanging</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hanged self with electric wire cord</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>11:00</b> a. m. <b>5-13-56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b>		20f. (City or town) (County) (State) <b>Hagerstown Washington Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-16-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>May 17, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Black Bowers</b>	

MEDICAL CERTIFICATION

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 21 1956

5567

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>902 Rose Hill Ave.</b>				d. STREET ADDRESS <b>902 Rose Hill Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Nichols</b>				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1867</b>	9. AGE (In years last birthday) yrs. <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Boward</b>				14. MOTHER'S MAIDEN NAME <b>Athelia Kershner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ethel M. Frielinghaus</b>		Address <b>Hillside, N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of arterio-venous aneurysm</b> <b>443X</b> DUE TO <b>behind left orbit</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arterio Sclerotic Cardio Vascular Disease</b> (c) <b>5 yrs +</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> 19____ to <b>28 May</b> 19 <b>56</b> , that I last saw the deceased alive on <b>27 May</b> 19 <b>56</b> , and that death occurred at <b>1 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>230 N Potomac Hagerstown Md</b> DATE SIGNED <b>29 May 56</b>							
ACTUAL SIGNATURE <b>F. F. Lusby</b>				M.D. <b>F. F. Lusby</b>			
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>May 31, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

956T 7 N00

RECEIVED

5568

## CERTIFICATE OF DEATH

Reg. Dist. No.

B02

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>1 day</b>				d. STREET ADDRESS <b>837 Florida Ave.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Snowden</b> Last <b>Paul</b>				4. DATE OF DEATH Month <b>5</b> Day <b>15</b> Year <b>19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 13, 1874</b>		9. AGE (In years, lost birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>coal miner</b>		11. BIRTHPLACE (State or foreign country) <b>Elizabeth, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>Laura Snowden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>193-03-9680</b>		17. INFORMANT <b>Laura Robison</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC GLOMERULONEPHRITIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>FEB 23</b> , 19 <b>52</b> , to <b>MAY 15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>MAY 14</b> , 19 <b>56</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CLEAR SPRING, MD</b> DATE SIGNED <b>5/15/56</b>							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.				PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-18-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Taylors</b>		22d. LOCATION (City, town, or county) (State) <b>Bunola Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>May 16, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Shasth Bower</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED ARCHIE ROBERT CHERN, M.D.		SEX Male		AGE 31	
DATE OF DEATH MAY 17, 1956		TIME OF DEATH 2:15 PM		PLACE OF DEATH 1010 N. E. Street, Baltimore, Md.	
CAUSE OF DEATH CHRONIC CLONURAL NEPHRITIS		MANNER OF DEATH Natural		PLACE OF BIRTH Baltimore, Md.	
DATE OF BIRTH MAY 18, 1924		PLACE OF BIRTH Baltimore, Md.		OCCUPATION Physician	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)	

RECEIVED  
 MAY 18 1956  
 BUREAU V. 5

6726

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Baby Boy Peterson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 13 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>May 13, 1956</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Douglas H. M. Peterson</u>				14. MOTHER'S MAIDEN NAME: <u>Wanda Yvonne James (from chart)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS: <u>W. Wooden, Wash. Co. Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
7625 IMMEDIATE CAUSE (A) <u>atelectasis</u>						2 1/4 hrs.	
ANTECEDENT CAUSE (S) DUE TO <u>Immaturity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/13, 1956</u> , to <u>5/13, 1956</u> , that I last saw the deceased alive on <u>5/13</u> , 1956, and that death occurred at <u>7<sup>55</sup> A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. D. Done</u>		M. D. <u>Hagerstown</u>		DATE SIGNED <u>8/27/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>5-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Washington County Hosp.</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Aug. 31, 1956</u>		REGISTRAR'S SIGNATURE <u>Blair Powers</u>		24. FUNERAL DIRECTOR <input checked="" type="checkbox"/>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 56

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 4 1956

BUREAU V. S.

5569

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>25 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>610 Summitt Ave.</u>		d. STREET ADDRESS <u>610 Summitt Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RHETTA</u> Middle <u>COBLE</u> Last <u>PONESMITH</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 13, 1873</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Earney, York County, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Coble</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Shellenbarger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Raye E. Bear</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIAL THROMBOSES LEFT</u> DUE TO <u>LEG</u> (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>1 indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>2-19-56</u> , 19 <u>56</u> , to <u>5-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 30</u> , 19 <u>56</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Harrison MD.</u>		ADDRESS (Street, city or town, state) <u>318 N. Potomac ST</u>	
PHYSICIAN'S NAME (Type) <u>PAUL HARRISON MD</u>		DATE SIGNED <u>5/31/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mechanicsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mechanicsburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ringer</u>		ADDRESS <u>Hagerstown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>May 31, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H. H.</u>	

MEDICAL CERTIFICATION

TO THE PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 7 JUN

RECEIVED



VS A15 (4)  
ISM 9/SS



MEDICAL CERTIFICATION

MAY 9 1956

RECEIVED

5694

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO - RURAL - X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REEDER NURSING HOME</u>				d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN EDWARD REMSBURG</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 19 - 1875</u>		9. AGE (In years last birthday) <u>81-2-20</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>FRED - CO - MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MCCAULEY REMSBURG</u>				14. MOTHER'S MAIDEN NAME <u>MARY RAYMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>220-30-9700</u>		17. INFORMANT <u>MRS. WARREN RUEFNER BOONSBORO MD. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 12, 1953</u> , to <u>May 15, 1956</u> , that I last saw the deceased alive on <u>May 15, 1956</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Boonsboro,</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 18 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>MAY 18 - 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. B...</u>	

MEDICAL CERTIFICATION

TO THE SPIRIT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the assistance of a physician. The physician who attended the deceased must sign the certificate. The certificate may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAY 21 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Dr. Wells 5570 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05580 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Potomac Ave.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u> d. STREET ADDRESS <u>220 E. Chestnut St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl Leroy Richter</u>				4. DATE OF DEATH Month Day Year <u>May 25 19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 20, 1900</u>	
9. AGE (in years last birthday) <u>56</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Appliance Potomac Edison Co. Rockland, Maine</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Otto Richter</u>			
14. MOTHER'S MAIDEN NAME <u>Fanny Day</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>17-10-9582</u>				17. INFORMANT Address <u>Mrs. Myra Richter 220 Chestnut St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic coronary heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE NATURE OF INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none 19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-26-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery Hagerstown, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>May 29, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Howard</u>	

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute this certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5695

## CERTIFICATE OF DEATH

05581

Reg. Dist. No. 314

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MT. BRIER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MT. BRIER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDYSVILLE MD. R.I.</u>				d. STREET ADDRESS <u>KEEDYSVILLE MD. R.I.</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM - FLAHERTY - ROHRER</u>				4. DATE OF DEATH <u>MAY-21-</u> 19 <u>56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL-12-1868</u>	9. AGE (In years last birthday) <u>88-1-9</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM.</u>		11. BIRTHPLACE (State or foreign country) <u>WASH.-CO. MD.</u>	
13. FATHER'S NAME <u>NO RECORD</u>				14. MOTHER'S MAIDEN NAME <u>NO RECORD.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS. D.E. SEVILLE</u>				Address <u>KEEDYSVILLE MD. R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>May 21</u> , 19 <u>56</u> , to <u>May 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>56</u> , and that death occurred at <u>10A N.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Boonsboro,</u>				DATE SIGNED <u>5/23/56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY-23-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. BRIER CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR KEEDYSVILLE MD. R.I.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>May 24. 56</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate is for the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove portion papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05582

5571

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>agerstown</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>Clearspring</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>May</b> Last <b>Rubeck</b>		4. DATE OF DEATH Month <b>5</b> Day <b>21</b> Year <b>19 56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1890</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>home duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland Co. Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Timmons</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Wagaman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-26-1270</b>	
17. INFORMANT <b>Amos Rubeck</b>		Address <b>Clearspring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung, right with metastasis</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 17, 19 56c</b> to <b>May 21, 19 56</b> , that I last saw the deceased alive on <b>May 20, 19 56</b> , and that death occurred at <b>2:00 am</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.		ADDRESS (Street, city or town, state) <b>Clear Spring, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		DATE SIGNED <b>5/21/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-23-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blairs Valley Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Blairs Valley Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b>		ADDRESS <b>Clearspring, Md.</b>	
24a. REC'D BY REGISTRAR <b>May 24 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>	

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		1910		Baltimore		Maryland		Maryland		United States	
RACE		COLOR		RELIGION		MARRIED		SINGLE		WIDOWED		DIVORCED		SEPARATED	
White		White		Roman Catholic		Married		Single		Widowed		Divorced		Separated	
EDUCATION		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING	
High School		High School		High School		High School		High School		High School		High School		High School	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
Salesman		Salesman		Salesman		Salesman		Salesman		Salesman		Salesman		Salesman	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
May 15, 1956		Baltimore		Baltimore		Maryland		United States		May 15, 1956		Baltimore		Baltimore	
CAUSE OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
Heart Disease		Natural		Natural		Natural		Natural		Natural		Natural		Natural	
DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE	
Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
May 15, 1956		Baltimore		Baltimore		Maryland		United States		May 15, 1956		Baltimore		Baltimore	

BUREAU V. 3

MAY 28 1956

RECEIVED

TO SPECIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 9, FlimG196 5-10-56 et										
5572 CERTIFICATE OF DEATH										
Reg. Dist. No. 05583										
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 60 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 E. LEE ST.					d. STREET ADDRESS 128 E. LEE ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) LULA ADELLA RUDY					4. DATE OF DEATH Month MAY Day 1 Year 1956					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/14/1864		9. AGE (In years last birthday) 91 8/7yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME			11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. POFFENBERGER					14. MOTHER'S MAIDEN NAME ELLEN HOFFMAN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT MR. CARL RUDY			Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 Day		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/30/56 to 5/1/56, 19____, that I last saw the deceased alive on 3/1/56, 19____, and that death occurred at 12:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Kathleen E. Young William H. Poffenberger										
ACTUAL SIGNATURE					PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 4/3/56		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment					ADDRESS Hagerstown, Md.		24. REC'D BY REGISTRAR May 4, 1956		24b. REGISTRAR'S SIGNATURE Blas H. Bowers	

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM H. ROYER		AGE 60		SEX MALE		RACE WHITE		DATE OF DEATH MAY 1 1956		PLACE OF DEATH HOSPITAL	
RESIDENCE 1234 5th St. N.W.		CITY WASHINGTON		STATE DISTRICT OF COLUMBIA		COUNTRY UNITED STATES OF AMERICA		DATE OF BIRTH MAY 1 1896		PLACE OF BIRTH HOSPITAL	
OCCUPATION None		CAUSE OF DEATH None		MANNER OF DEATH None		DISEASE OR INJURY None		DATE OF ONSET None		DATE OF EXAMINATION None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None		SIGNATURE OF REGISTRAR None		SIGNATURE OF CLERK None	

BUREAU V. 2

MAY 7 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5573

## CERTIFICATE OF DEATH

05584

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN 1b <b>39 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>317 Mitchell Ave</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>	
		d. STREET ADDRESS <b>317 Mitchell Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Raymond</b> Last <b>Ruthrauff</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22 1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardwood Floors</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Augustus Ruthrauff</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Corby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>176-07-8597</b>	
17. INFORMANT <b>Daisy Amelia Ruthrauff</b>		Address <b>317 Mitchell Ave Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive atherosclerotic Heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-6-56</b> , 19 <b>56</b> , to <b>5-10-56</b> , that I last saw the deceased alive on <b>5-7-56</b> , 19 <b>56</b> , and that death occurred at <b>2:30</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. E. W. Smith</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. E. W. Smith</b>		DATE SIGNED <b>5/10/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 12-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf</b>		ADDRESS <b>Williamsport Md.</b>	
24a. REC'D BY REGISTRAR <b>May 12, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES EDWARD		M		30 YRS.		JULY 1956	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
112 N. 10th St. St. Louis, Mo.		Carpenter		Heart Disease		Natural	
Physician		Hospital		Burial		Cremation	
Dr. J. H. Smith		St. Louis Hospital		St. Louis Cemetery		St. Louis Crematorium	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Date of Report		Place of Report		Name of Reporting Agency		Name of Reporting Person	
JULY 1956		St. Louis, Mo.		St. Louis Health Department		J. H. Smith	

RECEIVED  
MAY 15 1956  
BUREAU V. 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5574 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05585  
Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Paramount</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>99 Washington County Hospital</b>				d. STREET ADDRESS <b>R # 6 Hagerstown, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Joseph</b> Last <b>St. Martin</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 14, 1893</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aircraft Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchilds</b>		11. BIRTHPLACE (State or foreign country) <b>S. Manchester, Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jospeh S. Martin</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. W. # 1 213-18-8378</b>		17. INFORMANT <b>D.W. St. Martin, 930 Mt. Etna Rd., Hagerstown</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>  <b>420.1</b> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerotic coronary heart disease</b>            DUE TO (c) _____</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b></p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-19-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grossnickle's</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>				ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR <b>May 18, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Fred. C. C.</b>		DATE SIGNED <b>May 17 '56</b>	

MEDICAL CERTIFICATION

NECESSARY, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

MAY 21 1956

RECEIVED

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any case within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05586

Reg. Dist. No.

302

5575

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>601 West Franklin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Martin</u> Last <u>Sensabaugh</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Bridge Baths, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Walker Sensabaugh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Susan Benson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-30-9102A</u>	
17. INFORMANT <u>Mrs. Thomas M. Sensabaugh, Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse (Shock)</u> 577x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Incomplete Intestinal obstruction</u> DUE TO (c) <u>Intestinal adhesion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>2-3 days</u> <u>5 yrs(?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 6, 1954</u> , to <u>May 15, 1956</u> , that I last saw the deceased alive on <u>May 14, 1956</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> , M.D.		DATE SIGNED <u>217 W. Washington St.</u>	
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>217 W. Washington St., Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-18-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Bowers</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>May 17, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>	

RECEIVED



5576

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>58 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>23 S. Mulberry</b>		d. STREET ADDRESS <b>23 S. Mulberry</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Funk</b> Last <b>Shaffner</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1886</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Waynesborop Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Allen Shaffner</b>		14. MOTHER'S MAIDEN NAME <b>Jane Straley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-24-9610</b>	
17. INFORMANT Address <b>Mrs. Grace J. Shaffner Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arterio-sclerotic myocardial heart disease</b> DUE TO (b) <b>acute coronary occlusion</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>October 1945</b> to <b>May 3, 1956</b> , that I last saw the deceased alive on <b>April 6, 1956</b> , and that death occurred at <b>12:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		ADDRESS (Street, city or town, state) <b>115 N. Potomac St- Hagerstown, Md</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DATE SIGNED <b>5-4-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-5-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hagerstown Md.</b> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>May 8, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Shaffner</b>	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5577

## CERTIFICATE OF DEATH

05588

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>1 WK.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FUNKSTOWN</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>			d. STREET ADDRESS <b>16 W. CEMETERY ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>GLADYS</b> <b>ISABEL</b> <b>SHANK</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1956</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/16/1896</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>ALBERT T. SHILLING</b>			14. MOTHER'S MAIDEN NAME <b>SARAH D. EAKLE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. CHARLES F. SHANK</b> Address <b>FUNKSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism with Right Hemiplegia</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease with Mitral Stenosis &amp; Auricular Fibrillation</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b> <b>40 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>8-21</b> , <b>1948</b> , to <b>5-10</b> , <b>1956</b> , that I last saw the deceased alive on <b>5-10</b> , <b>1956</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>998 Potomac Ave., Hagerstown, Md.</b> DATE SIGNED <b>5-12-56</b> ACTUAL SIGNATURE <b>Dalton M. Welty</b> PHYSICIAN'S NAME (Type) <b>Dalton M. Welty, M.D.</b>					
22a. BURIAL, CREMATION, REINTERMENT	22b. DATE THEREOF <b>5/13/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FUNKSTOWN CEM.</b>	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>			24a. REC'D BY REGISTRAR <b>May 14, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Blas H. Bowers</b>	

MEDICAL CERTIFICATION

BUREAU V. 3

1956 16 JAN

RECEIVED

5696

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REEDER NURSING HOME</u>				e. STREET ADDRESS <u>SOUTH MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>UPTON SHERIDAN SINNISEN</u>				4. DATE OF DEATH Month Day Year <u>MAY - 3 - 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1869</u>	9. AGE (In years last birthday) <u>87-2-23</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER OWN FARM</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CHAMBERSBURG PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEARY R. SINNISEN</u>				14. MOTHER'S MAIDEN NAME <u>EMMA WALBURN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MISS FLORENCE SINNISEN</u>				Address <u>BOONSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse.</u> <u>179X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized wasting from ca;</u> DUE TO (c) <u>Carcinoma of Penis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>months</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>May 2</u> , 19 <u>56</u> , to <u>May 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis G. Graff</u>				ADDRESS (Street, city or town, state) <u>M.D. 119 E. Antietam St.</u>			
PHYSICIAN'S NAME (Type) <u>Louis G. Graff, M.D.</u>				DATE SIGNED <u>May 4</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY-6-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>John H. Best</u>	
				DATE <u>MAY-6-1956</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		OCCUPATION	
EDUCATION		MARRIAGE		SINGLE		MARRIED		WIDOWED	
PREVIOUS MARRIAGES		DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
CITY OF RESIDENCE		COUNTY OF RESIDENCE		STATE OF RESIDENCE		COUNTRY OF RESIDENCE		OCCUPATION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		OCCUPATION	
EDUCATION		MARRIAGE		SINGLE		MARRIED		WIDOWED	
PREVIOUS MARRIAGES		DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
CITY OF RESIDENCE		COUNTY OF RESIDENCE		STATE OF RESIDENCE		COUNTRY OF RESIDENCE		OCCUPATION	

RECEIVED  
MAY 9 1956  
BUREAU V. S.

5578

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>17 Public Square</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BESSIE</u> <u>MAE</u> <u>SMITH</u>				4. DATE OF DEATH Month Day Year <u>May 17</u> <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18, 1877</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rockford, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lookabaugh</u>				14. MOTHER'S MAIDEN NAME <u>Joan Fessler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Islene Heflin Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/19</u> , 19 <u>56</u> , to <u>5/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/10</u> , 19 <u>56</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>D. J. [Signature]</u> M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/19/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. J. [Signature]</u> ADDRESS <u>Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>May 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO BE SIGNED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1534

BUREAU V. S.

MAY 22 1956

RECEIVED  
MAY 22 1956

5697

## CERTIFICATE OF DEATH

Reg. Dist. No.

307

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCUST GROVE RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCUST GROVE - RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROHRSVILLE MD.</u>		d. STREET ADDRESS <u>ROHRSVILLE MD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL H SNYDER</u>		4. DATE OF DEATH Month Day Year <u>MAY - 11 - 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-7-1875</u>
9. AGE (In years last birthday) <u>80-84</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>- - -</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER. PUBLIC SCHOOLS LOCUST GROVE WASH. CO. MD.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN T. SNYDER</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA STINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOHN D. SNYDER</u>		Address <u>ROHRSVILLE WASH. CO. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Haemorrhage</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>18 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>56</u> , to <u>May 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Calkins</u> M.D. <u>Boonsboro</u>		ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>5/13/56</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY-14-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOCUST GROVE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>LOCUST GROVE WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME BOONS BORO MD.</u>		24a. REC'D BY REGISTRAR <u>May 15-1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Katherine Sargent</u>	

MEDICAL CERTIFICATION

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be made out by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 16 1956

RECEIVED



5579

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. STREET ADDRESS <u>17 High St.</u>			
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>INDIANA</u> Last <u>SNYDER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 8 1905</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank H. Beckley</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Weller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>R. Beckley Snyder</u> Address <u>Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic Heart Disease with Mitral Stenosis and Insufficiency</u>							19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>11-24</u> , 19 <u>52</u> , to <u>5-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-28</u> , 19 <u>56</u> , and that death occurred at <u>3:40AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dalton M. Welty</u>				ADDRESS (Street, city or town, state) <u>998 Potomac Ave., Hagerstown, Md</u>			
PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M. D.</u>				DATE SIGNED <u>5-28-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>May 31, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blair H. Rowers</u>			

MEDICAL CERTIFICATION

0354

BUREAU V. S.

UN 4 1956

RECEIVED

5580

## CERTIFICATE OF DEATH

05593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>14 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>134 Broadway</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marguerite Bauserman Sours</b>		4. DATE OF DEATH Month Day Year <b>May 10 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 11, 1905</b>
9. AGE (In years last birthday) yrs. <b>51</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Luray Va,</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James R. Bauserman</b>		14. MOTHER'S MAIDEN NAME <b>Flora Bradley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-18-0742</b>	
17. INFORMANT <b>Paul H. Sours</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Visceral Carcinomatosis</b> DUE TO 175x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma, right ovary</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>  <b>Unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/7/56</b> , 19____, to <b>5/10/56</b> , 19____, that I last saw the deceased alive on <b>5/10/56</b> , 19____, and that death occurred at <b>9:30A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>148 N. Potomac St., Hagerstown, Md., 5/11/56</b>			
ACTUAL SIGNATURE <b>S. Earl Young</b> M.D. PHYSICIAN'S NAME (Type) <b>S. Earl Young, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 12, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	24a. REC'D BY REGISTRAR <b>May 14 1956</b>
		24b. REGISTRAR'S SIGNATURE <b>Wash Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 16 1956

RECEIVED

5581

## CERTIFICATE OF DEATH

Dr Wells

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>106 Wayside Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>LEON</u> Last <u>SPESSARD Sr</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1900</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Salesman-Hoffman Chevrolet</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cleggett A. Spessard</u>				14. MOTHER'S MAIDEN NAME <u>Annie M. Whitmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>314-09-3533</u>		17. INFORMANT <u>Mr. Russell L. Spessard</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease with failure</u> <u>420.0</u> DUE TO <u>grade iv</u> mitral stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>None</u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Oct. 1955</u> , to <u>May 28, 1956</u> , that I last saw the deceased alive on <u>May 28, 1956</u> , and that death occurred at <u>2:15 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 N. Potomac St- Hagerstown, Md.</u> DATE SIGNED <u>5-29</u>							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. <u>115 N. Potomac St- Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>June 1, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



NEWYORK STATE DEPARTMENT OF HEALTH-DIVISION OF

9506 7 N11

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 055192

1. PLACE OF DEATH a. COUNTY Washington 5698 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Susanna O. Stockman		4. DATE OF DEATH Month 5 Day 22 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Armister Alexander		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address William Beachley, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.7 Fractured Hip DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Sclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell while getting out of bed	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that I attended the deceased from Dec 14, 1953 to May 22, 1956 that I last saw the deceased alive on 5/21, 1956, and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Clear Spring Md.	
PHYSICIAN'S NAME (Type) Dr. David Brewer		Clearspring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/1956	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Middletown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		24a. REC'D BY REGISTRAR May 26 1956	24b. REGISTRAR'S SIGNATURE Joseph H. Murray

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYLAND		M		68		1892		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
MAY 31 1956		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
TIME OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED		DIVORCED	
10:00 AM		CLOCK REPAIRER		HIGH SCHOOL		METHODIST		MARRIED		WIFE		MARRIED		MARRIED	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF CHAPLAIN		SIGNATURE OF RABBI		SIGNATURE OF OTHER	
DATE OF ENTRY		PLACE OF ENTRY		CITY OF ENTRY		STATE OF ENTRY		COUNTRY OF ENTRY		CAUSE OF ENTRY		MANNER OF ENTRY		DISEASE OR INJURY	
MAY 31 1956		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
TIME OF ENTRY		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED		DIVORCED	
10:00 AM		CLOCK REPAIRER		HIGH SCHOOL		METHODIST		MARRIED		WIFE		MARRIED		MARRIED	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF CHAPLAIN		SIGNATURE OF RABBI		SIGNATURE OF OTHER	

BUREAU V. S.

MAY 31 1956

RECEIVED



BUREAU V. S.



5583

## CERTIFICATE OF DEATH

05597 Dr Binford

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>50 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				d. STREET ADDRESS <u>830 Dewey Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>May</u> Last <u>Trovinger</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1882</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Chrisman</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Wroe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Edgar C Trovinger</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Generalized arteriosclerosis</u> (c) <u>years.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, emphysema.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 April, 1956</u> , to <u>17 May 1956</u> , that I last saw the deceased alive on <u>17 May, 1956</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>18 May 56</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>				<u>HAGERSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. COFFMAN</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>May 21, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 makes the certificate valid for use by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
HASTINGS		MALE		35		JAN 1 1921		BOSTON		MASSACHUSETTS		UNITED STATES	
MARRIAGE		MARRIED		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
EDUCATION		HIGH SCHOOL		12		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
OCCUPATION		CLERK		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
CAUSE OF DEATH		HEART DISEASE		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
MANNER OF DEATH		NATURAL		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
PLACE OF DEATH		HOME		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
DATE OF DEATH		JUN 15 1945		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
TIME OF DEATH		10:00 AM		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
SIGNATURE OF DECEASED		HASTINGS		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
SIGNATURE OF WITNESS		HASTINGS		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
SIGNATURE OF PHYSICIAN		HASTINGS		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
SIGNATURE OF CLERK		HASTINGS		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	
SIGNATURE OF REGISTRAR		HASTINGS		10		JUN 15 1945		BOSTON		MASSACHUSETTS		UNITED STATES	

BUREAU V. B.

MAY 23 1956

RECEIVED

LABORATORY, BUREAU OF VITAL RECORDS

RECEIVED, BUREAU OF VITAL RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4, make a copy of this certificate and file it with the hospital or attending physician.)  
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05598

Item 22b Film G199 6/28/56.  
Dr. Hornbaker

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>15 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>81 Washington County Hospital</u>				d. STREET ADDRESS <u>1139 Hamilton Blvd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>ELIAS</u> Last <u>WELSH</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 25, 1896</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt of Hagerstown Div W.M.R.R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Elk Garden, W.Va.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Edward E. Welsh</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>05-10-6222</u>		17. INFORMANT <u>Mr. Grant E. Welsh-1139 Hamilton Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>4.43X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>40 minutes</u> <u>About 19 years -</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>4-15-1939</u> to <u>5-7-1956</u> , that I last saw the deceased alive on <u>5-7-1956</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.				ADDRESS (Street, city or town, state) <u>154 W. Washington St. - Hagerstown</u>			
DATE SIGNED <u>5/7/56</u>							
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>				<u>154 W. Washington St. - Hagerstown</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>May 11, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Bowers</u>	

BUREAU V. S.

MAY 14 1956

RECEIVED

5585

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown Md.</u>			
c. LENGTH OF STAY IN 1b <u>Infant</u>				d. STREET ADDRESS <u>R.F.D. 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jefery E Werdebaugh</u>			4. DATE OF DEATH <u>5 15 19 56</u>			Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5.15.56</u>		9. AGE (In years last birthday) yrs. <u>1</u> Min. <u>40</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Washington County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph T Werdebaugh</u>				14. MOTHER'S MAIDEN NAME <u>Clara C Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ralph T Werdebaugh R.F.D.2 Hagerstown Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital (Primary) Atelelectasis</u> <u>762.5</u> DUE TO (b) <u>Premature Birth - 7 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>7 months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/15/56</u> , 19 <u>56</u> , to <u>5/15</u> , 19 <u>56</u> that I last saw the deceased alive on <u>5/15</u> , 19 <u>56</u> , and that death occurred at <u>6:30 p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>5/18/56</u>							
ACTUAL SIGNATURE <u>George Jennings</u>		M.D. <u>George Jennings</u>					
PHYSICIAN'S NAME (Type) <u>George Jennings</u>		Hagerstown, Md					
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5.18.56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Piney Plains Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Little Orleans Allegany Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hume</u> ADDRESS <u>Hancock Md</u>				24. REC'D BY REGISTRAR <u>May 24. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	

TO BE SIGNED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. 3

MAY 28 1956

RECEIVED

5586

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>14 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>329 Brookline Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLAUDE</u> Middle <u>HENRY</u> Last <u>WETZEL</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 16, 1894</u>	9. AGE (In years last birthday) yrs. <u>61</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wiring Dept.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Libertytown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William G. Wetzel</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Poole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-16-1415</u>		17. INFORMANT <u>Mrs. Mary Wetzel</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic heart disease</u> cause (c), stating the underlying cause last. (c) <u>(2 previous coronary occlusions)</u> INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u> <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5-9-1953</u> , to <u>5-19-1956</u> , that I last saw the deceased alive on <u>2-4-1956</u> , and that death occurred at <u>11 A.</u> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Hornaker</u> M.D. <u>154 W. Washington St.</u>				<u>5-20-56</u>			
PHYSICIAN'S NAME (Type) <u>Hagerstown - Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/22/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Libertytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hornaker</u> ADDRESS <u>Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>May 21 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

2278

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

FILE NO. 100-100000

COUNTY OF BALTIMORE

DECEASED

MARRIAGE

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

MAY 23 1956

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5587

## CERTIFICATE OF DEATH

05601

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 37 W. Wilson Blvd.			
3. NAME OF DECEASED (Type or print) Naomi Virginia Wolfe				4. DATE OF DEATH May 29, 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1912	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk Fairchild Air Craft Corp		10b. KIND OF BUSINESS OR INDUSTRY Washington County, Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Clinton Hemphill				14. MOTHER'S MAIDEN NAME Florence Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-09-5347		17. INFORMANT Norman W. Wolfe 37 W. Wilson Blvd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, abdominal 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Krukenberg Tumor DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months 5 months				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown Md.				20g. (County) Washington		20h. (State) Maryland	
21. I certify that I attended the deceased from Dec. 8, 1955, 19 to May 29, 1956, 19, that I last saw the deceased alive on May 28, 1956, 19, and that death occurred at 3:20 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Haak				ADDRESS (Street, city or town, state) Williamsport, Md.			
PHYSICIAN'S NAME (Type) Paul Haak, M. D.				DATE SIGNED 29 May '56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/56		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR May 31, 1956	
24b. REGISTRAR'S SIGNATURE E. H. Bowers							

Andrew K. Coffman Hagerstown Md.

Burial 6/1/56 Rest Haven Cemetery

Hagerstown Md.

RECEIVED

JUN 4 1956

BUREAU V. S.

No

214-08-5347

Norman W. Wolfe 37 W. Wilson Blvd  
Hagerstown Md.

Clinton Hemphill

Florence Bowers

Pile Clerk Tailorbid Air Craft Corp

4 Weeks

Hagerstown



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be completed and returned to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5588

## CERTIFICATE OF DEATH

Reg. Dist. No.

05602

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u> 75x-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sylvan Penna.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Charlotte Younker</u>				4. DATE OF DEATH Month Day Year <u>May 27 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6 1894</u>	
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin County Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Barbiness Koefer</u>				14. MOTHER'S MAIDEN NAME <u>Ida Weller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edward J Younker R.F.D.2 Hancock Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>585X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>localized Peritonitis</u> DUE TO (c) <u>Cholecystitis Acute with Perforation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>10 days</u> <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>18 May, 1956</u> to <u>27 May, 1956</u> , that I last saw the deceased alive on <u>27 May, 1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Frank E Brumback M.D. 170 West Washington St</u> ACTUAL SIGNATURE Frank E Brumback Hagerstown Maryland PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5.30.56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stone Bridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Hancock Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone Hancock Md</u>				24. REC'D BY REGISTRAR <u>June 1, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>Frank F. Brumback</i></p>		<p>2. SEX <i>M</i></p>		<p>3. AGE <i>52</i></p>	
<p>4. DATE OF DEATH <i>June 7, 1956</i></p>		<p>5. TIME OF DEATH <i>10:00 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>10. OCCUPATION <i>None</i></p>		<p>11. EDUCATION <i>High School</i></p>		<p>12. RELIGION <i>None</i></p>	
<p>13. MARITAL STATUS <i>Married</i></p>		<p>14. DATE OF MARRIAGE <i>1915</i></p>		<p>15. NAME OF SPOUSE <i>Elizabeth</i></p>	
<p>16. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>17. NAME OF HOSPITAL <i>None</i></p>		<p>18. NAME OF NURSE <i>None</i></p>	
<p>19. NAME OF CORONER <i>None</i></p>		<p>20. NAME OF BURIAL PLACE <i>None</i></p>		<p>21. NAME OF FUNERAL HOME <i>None</i></p>	
<p>22. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>23. SIGNATURE OF CORONER <i>[Signature]</i></p>		<p>24. SIGNATURE OF DECEASED <i>[Signature]</i></p>	

BUREAU V. E.

JUN 7 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5589 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 Reg. Dist. No. **05603**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Washington</b></span>																																																																										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>																																																																										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>453 W. Antietam St.</b>				d. STREET ADDRESS <b>453 W. Antietam St.</b>																																																																										
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Alonza</b> Middle <b>Aaron</b> Last <b>Zimmerman</b>				<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>9</b> Year <b>19 56</b>																																																																										
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>																																																																										
<b>8. DATE OF BIRTH</b> <b>Jan. 26, 1884</b>		<b>9. AGE</b> (In years last birthday) <b>72</b> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.																																																																					
IF UNDER 1 YEAR	IF UNDER 24 HRS.																																																																													
Months	Days																																																																													
Hours	Min.																																																																													
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Railroad</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington Co. Md.</b>																																																																										
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>																																																																														
<b>13. FATHER'S NAME</b> <b>Frank A. Zimmerman</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Eliza Repp</b>																																																																											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-09-2490</b>		<b>17. INFORMANT</b> <b>Aaron G. Zimmerman</b>																																																																										
<b>3216 Address White Ave. Baltimore 14, Md.</b>																																																																														
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Exsanguination</b> </td> <td rowspan="3"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </td> </tr> <tr> <td colspan="2"> <b>977X</b>  <b>DUE TO</b> </td> </tr> <tr> <td colspan="2"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> </tr> <tr> <td colspan="3"> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> </td> <td colspan="3"> <b>19. WAS AUTOPSY PERFORMED?</b>  <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> </td> <td colspan="4" style="vertical-align: top;"> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  <b>Severed veins flexure surface both forearms with straight razor</b> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>20c. TIME OF INJURY</b> Month, Day, Year  <b>12:30 p.m. 5-9 1956</b> </td> <td colspan="2" style="vertical-align: top;"> <b>20d. INJURY OCCURRED</b>          While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> </td> <td colspan="2" style="vertical-align: top;"> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  <b>at home</b> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>20f. (City or town)</b>  <b>Hagerstown</b> </td> <td colspan="2" style="vertical-align: top;"> <b>(County)</b>  <b>Wash.</b> </td> <td colspan="2" style="vertical-align: top;"> <b>(State)</b>  <b>Md</b> </td> </tr> <tr> <td colspan="6" style="vertical-align: top;"> <b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> </td> </tr> <tr> <td colspan="3" style="vertical-align: top;"> <b>ACTUAL SIGNATURE</b> <i>S. Robert Wells</i> </td> <td colspan="3" style="vertical-align: top;"> <b>DATE SIGNED</b>  <b>May 10, 1956</b> </td> </tr> <tr> <td colspan="3" style="vertical-align: top;"> <b>EXAMINER'S NAME (Type)</b>  <b>S. Robert Wells, M.D.</b> </td> <td colspan="3" style="vertical-align: top;"> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>  <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>  <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>  <b>Burial</b> </td> <td colspan="2" style="vertical-align: top;"> <b>22b. DATE THEREOF</b>  <b>May 12, 1956</b> </td> <td colspan="2" style="vertical-align: top;"> <b>22c. NAME OF CEMETERY OR CREMATORY</b>  <b>Rest Haven Cemetery</b> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>22d. LOCATION (City, town, or county)</b>  <b>Hagerstown</b> </td> <td colspan="4" style="vertical-align: top;"> <b>(State)</b>  <b>Md.</b> </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> <b>23. FUNERAL DIRECTOR'S SIGNATURE</b>  <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b> </td> <td colspan="2" style="vertical-align: top;"> <b>24a. REC'D BY REGISTRAR</b>  <b>May 11 1956</b> </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> <b>ADDRESS</b>  <i>Wm. C. Horst &amp; Co.</i> </td> <td colspan="2" style="vertical-align: top;"> <b>24b. REGISTRAR'S SIGNATURE</b>  <i>Blair H. ...</i> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Exsanguination</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	<b>977X</b> <b>DUE TO</b>		<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Severed veins flexure surface both forearms with straight razor</b>				<b>20c. TIME OF INJURY</b> Month, Day, Year <b>12:30 p.m. 5-9 1956</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>at home</b>		<b>20f. (City or town)</b> <b>Hagerstown</b>		<b>(County)</b> <b>Wash.</b>		<b>(State)</b> <b>Md</b>		<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						<b>ACTUAL SIGNATURE</b> <i>S. Robert Wells</i>			<b>DATE SIGNED</b> <b>May 10, 1956</b>			<b>EXAMINER'S NAME (Type)</b> <b>S. Robert Wells, M.D.</b>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>May 12, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Rest Haven Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Hagerstown</b>		<b>(State)</b> <b>Md.</b>				<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>May 11 1956</b>		<b>ADDRESS</b> <i>Wm. C. Horst &amp; Co.</i>				<b>24b. REGISTRAR'S SIGNATURE</b> <i>Blair H. ...</i>	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Exsanguination</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>																																																																												
<b>977X</b> <b>DUE TO</b>																																																																														
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>																																																																														
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>																																																																											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Severed veins flexure surface both forearms with straight razor</b>																																																																												
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>12:30 p.m. 5-9 1956</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>at home</b>																																																																										
<b>20f. (City or town)</b> <b>Hagerstown</b>		<b>(County)</b> <b>Wash.</b>		<b>(State)</b> <b>Md</b>																																																																										
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																																																																														
<b>ACTUAL SIGNATURE</b> <i>S. Robert Wells</i>			<b>DATE SIGNED</b> <b>May 10, 1956</b>																																																																											
<b>EXAMINER'S NAME (Type)</b> <b>S. Robert Wells, M.D.</b>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>																																																																											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>May 12, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Rest Haven Cemetery</b>																																																																										
<b>22d. LOCATION (City, town, or county)</b> <b>Hagerstown</b>		<b>(State)</b> <b>Md.</b>																																																																												
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>May 11 1956</b>																																																																										
<b>ADDRESS</b> <i>Wm. C. Horst &amp; Co.</i>				<b>24b. REGISTRAR'S SIGNATURE</b> <i>Blair H. ...</i>																																																																										

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other party, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 14 1956

RECEIVED